The Transition to

Community Support Services

for

Children in Public Schools

Workbook and Guidelines

February 2006

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

And

North Carolina Department of Instruction
Division of Exceptional Children

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Introduction to Transition

Why are we changing to new services for children?

The transformation of mental health, developmental disabilities and substance abuse services (MH/DD/SAS) in North Carolina[1] is affecting services for children in the public school environment. Primarily, this transformation is due to the commitment of the North Carolina legislature and human services professionals to focus on the best practices available for children with MH/DD/SA problems.

The goal of this transformation is for evidence based and best practice models of care to be provided for children in a family based and community setting as much as possible. The effort is to provide a stable community setting with necessary support to maintain children in their families or a family-type setting. This also suggests that the child be maintained in a consistent school setting as well.

Over the last two years, best practice models of care have been identified, documented and carefully reviewed by the Division of MH/DD/SAS, the Division of Medical Assistance (DMA) and its Physicians Advisory Group; and finally, they were approved by the federal Centers of Medicare and Medicaid (CMS).[2] The services approved as best practices are included in North Carolina's Medicaid State Plan and will be paid for by Medicaid funds for those children and families who are eligible for Medicaid.

As a result, some services that have been provided through area or county MH/DD/SA programs and private providers are no longer on the list of approved services because they are not best practices. In particular, a service known as Community Based Services (CBS) is not considered best practice and is no longer on the list of approved services to be provided by MH/DD/SA providers.

Community Support (CS) is a newly approved best practice that will be provided instead of CBS. In general, Community Support is focused on skill building for the student and family with support and consultation available with the school personnel who work with the child. In the school setting the goal of Community Support is to support autonomy and independence for the child as he or she learns to control his or her own behavior. This intervention will also work in a collaborative fashion with school personnel to develop specific interventions that will be effective in supporting the child in remaining safely and appropriately in the classroom setting.[3]

Who is affected?

During state fiscal year 2004-2005, over 80,000 children in North Carolina received MH/DD/SA services through the public services system. Of these, between 4,000 and 7,000 children received

[1] The reform of the mental health system began in 2001 with a legislative mandate to transform the way services for mental health, developmental disabilities and substance abuse services are provided in NC. See appendix A for more information about the reform effort in NC.
[2] The service definitions approved by CMS can be found at: http://www.dhhs.state.nc.us/mhddsas/
[3] Answers to frequently asked questions about Community Support can be found in appendix B and on the DMH/DD/SAS web site shown above.

CBS on a monthly basis during the school year. In many counties, these services were provided to children in the school environment as a way to support children in the classroom. These children, their families and personnel of those local school systems are affected by this change.

In addition, private providers who want to provide Community Support (CS) services must go through an endorsement process by a local management entity (LME) and must enroll with DMA in order to bill Medicaid directly for the newly approved services.

When does this transition occur?

The newly approved services go into effect on March 20, 2006. A copy of the memorandum from the directors of DMH/DD/SAS and DMA announcing this date of implementation can be seen on the DMH/DD/SAS web site at:
http://www.dhhs.state.nc.us/mhddsas/announce/servdefimplementation1-19-06dmadmh-memo.pdf

What is the vision for this transition?

The vision for the transition is of a local partnership and collaborative effort that will ultimately bring services for a child and family together to keep the child in school and in the community. Therefore, the active involvement of the schools in this reform effort is imperative. If we can succeed in keeping students in class and ultimately graduating from high school, we will have addressed collaboratively many of the problems that cause our drop out rate to be unacceptably high and the problems that young people are likely to experience if they do drop out.

Many of the children using these services are often involved in other child serving agencies such as local departments of social services and public health, and sometimes juvenile courts. We need to coordinate our efforts through child and family teams, the individual education program process and the development of person-centered plans. This will encourage not only professional interventions, but also supports for families and children from extended families and from their communities.

Child and family teams can successfully collaborate for the child with everyone at the table. A team can meet at different locations in the community, such as at the child's school, to develop a person-centered plan including natural and community supports, school services, mental health services and crisis planning.

How do we prepare for this transition?

As described in the DVD provided with this workbook, both the Department of Health and Human Services (DHHS) Division of MH/DD/SAS and the Department of Public Instruction (DPI) Exceptional Children Division recommend that each local management entity (LME) of MH/DD/SA services work with each local education agency (LEA) in their geographic area to decide how they will operate together. Because local school systems are autonomous, the agreements may differ from county to county. Maps of the LMEs and the LEAs are shown in appendices C and D.

The State requests that each LME and each LEA work collaboratively to plan for this transition locally and to provide consultation to each other as needed.[4] This is an opportunity to build a strong working relationship between the LME and the LEA and to effectively communicate these changes to providers of services and to the families and children we serve. These changes will in most instances be difficult and anxiety provoking for the families involved. It is critical that we communicate frequently and effectively.

On March 20 the services received by many children will not appear that different, but over time the type of service and the number of hours of service in the school environment will change. For the majority of children served by Community Support starting on March 20, the authorization of services will be automatic for up to the first 30 days.[5]

Initially, the frequency and duration of Community Support may be very similar to CBS, with reviews of additional requests for service conducted at points as a child's individual education program is reviewed, or as reauthorization of services by the LME occurs, or as a new person-centered plan is developed. The reviews will be conducted in the context of and with recommendations from the child and family teams.

For those children with the most critical needs, attention is needed by the provider, school and the child and family team to plan services immediately. There are a limited number of children with developmental disabilities who will lose CBS services and will not be eligible for Community Support. This is a small group in the state, but it is critical to meet their needs. These will be addressed on a case by case basis.

The process of transition will be one of gradually maturing providers to delivering the full definition of Community Support. In order to provide the service called Community Support, a provider must first be endorsed by the LME. This endorsement will assure that provider has met qualifications for this definition to provide the service.

The role of the school is to facilitate this transition. School personnel should be proactive in identifying the children in their schools who currently receive CBS and their current providers and contact the LME to ask if Community Support services will be authorized for each child.

If the amount of services is reduced or the service will not longer be available, as in the case of students with developmental disabilities with no mental health diagnosis, the IEP team for the student should meet as soon as possible. The current provider of CBS should be included at that meeting. The IEP team needs to consider services and supports the student will need in order to continue to benefit from education at school. This does not mean automatically providing a one-on-one assistant to these students. In many cases the existing program and staff may be able to provide the supports needed for the student. Each student's IEP team must determine what the student needs to receive in the current education program.

Each LEA must examine existing school programs and staffing to determine if changes in programming needs to occur to meet the needs of those students who may not be covered by the

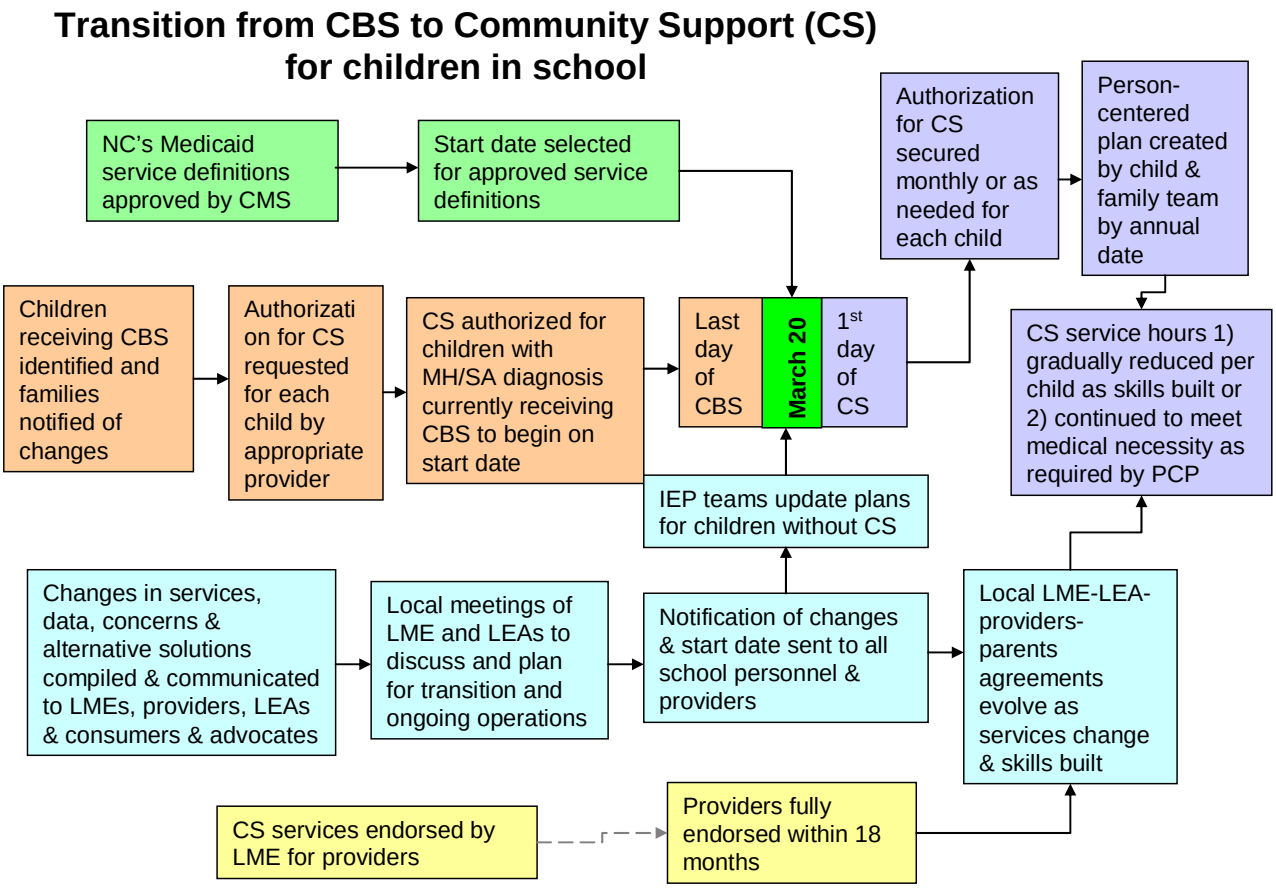
[4] See a memorandum from Mary Watson, Director, Exceptional Children Division, DPI dated January 20, 2006 in appendix E.

[5] See the service definition of Community Support – Children/Adolescents for information on reauthorization – on the DMH/DD/SAS web site at: http://www.dhhs.state.nc.us/mhddsas/

new service definitions. Some children may be eligible for additional funding through a special state reserve fund.[6]

In addition to the collaboration between LMEs and LEAs, considerable coordination is needed between LMEs and providers and between providers and the families they serve.

In general, there are several steps that must be accomplished for transition to occur. These steps are shown in the following diagram.



[6] Information about additional funding can be found on the Exceptional Children Division web site at: http://www.dpi.state.nc.us/ec/.

Purpose of this Workbook

The purpose of this workbook is to assist LMEs and LEAs in their discussions about significant issues and come to agreements about how children will receive mental health, developmental disabilities and substance abuse services in the school setting. Discussions and agreements may also involve providers and families. [7]

Local Joint Planning Tasks			
Parents & Children	Providers	LMEs	LEAs
If current user of CBS, contact case manager or CBS worker and schedule meeting to plan Community Support services.	Case manager or CBS provider notifies parents/children who receive CBS that authorization for CS is needed before March 20.	Collaborate with LEAs on process of transition and provide consultation on special cases.	Collaborate with LMEs on process of transition and provide consultation on special cases.
Child and family choose provider.	Provider becomes endorsed by LME to provide Community Support services.	Notifies providers and child/family consumers that CBS will be replaced by Community Support on March 20.	Review and revise IEPs of students who will have a reduction in services at school to provide additional supports.
Child and family team revises/prepares a person-centered plan for child and family no later than their annual review date.	Provider enrolls with DMA.	Endorse providers for Community Support services.	Agree with LME on the solutions to issues related to long term planning of services, including confidentiality and sharing of information and outcomes data.
	Provider meets with child & family team to develop PCP.	Provide list of endorsed CS providers to child & family for choice.	
		Review PCP and authorize frequency and duration of CS.	

The workbook was developed by a task force of DPI, LEA, LME, providers and DMH/DD/SAS representatives and reflects the issues, necessary decisions, and examples of practices that have been successful in various North Carolina communities. Some of the documents were developed

[7] The workbook can be found at the following web site:
http://www.dhhs.state.nc.us/mhddsas/childandfamily/index-new.htm

by LEAs as they defined how to most effectively work with private providers in their school systems.

The workbook and DVD are distributed through the LMEs for a single point of distribution, but are designed for use by LEAs, individual schools, providers, families and advocates as well as LMEs.

Suggested Tasks and Timeline

The following table of tasks and timeframes shows one approach to preparing locally for the March 20 implementation of Community Support. Some LMEs and LEAs may have already begun the process.

Between (dates)	Task	Responsibility
February 10 - 15	LME director and appropriate staff receive the workbook and DVD	DMH/DD/SAS and LME Liaison Team
February 13 - 17	LME provides information to and agrees with providers how and when families will be notified about change to Community Support and their choices	LME
February 13 - 28	LME meets with each LEA in their catchment area to discuss and agree on issues and procedures	LME to call the meeting; LEA to participate
February 20 - 28	LEA identifies all children in their school system receiving CBS now	LEA with each school and with providers and parents
February 20 - 28	Every family whose child receives CBS now knows how the change to the new service definitions on March 20 will affect them and what their choices are	LME or Providers
February 20 – 28	LEA confirms with LME which children will not be authorized for Community Support services	LEA and LME
February 20 – March 8	Each family selects a provider of Community Support and approves a revised service plan	Family and Provider (or LME by default)
February 22 - March 10	Every provider submits request for authorization for Community Support for every child/family they serve if MH or SA diagnosis	Providers
By March 20	All children with developmental disabilities diagnosis only have a plan for the educational setting	LEA (with IEP or other team)
By March 20	All children with MH or SA diagnosis are authorized for 30 days of Community Support to begin on March 20	Community Support Provider and LME

Worksheet

This worksheet is designed to assist in the documentation of the discussions and agreements between LMEs and LEAs and other participants.

Local participants in discussion

	Names	Contact Information	Email addresses
LME Representatives			
LEA Representatives			
Provider Representatives			
Family Representatives			

Note: See the maps in appendices C and D and a table of contacts by LME area and by county in appendix F.

Meetings

Date	Location	Time

Rights and Responsibilities

Notes: Add other rights and/or responsibilities specific to your area. Note how rights and responsibilities will be monitored or upheld.

Family/Advocate/ Agency/Organization	Rights and/or Responsibilities – Who monitors and/or enforces

How a Child/Family Transition from CBS to Community Support (& other relevant services)

Note the steps to be taken and by whom and by when; for example, a child and family team will meet to write the person-centered plan on xxx date.

Who/When	Action Plan

Provision of Services

Note what the LME's procedure is for accessing services, how services will be provided in the schools, and how families can request a person-centered plan review, or file a complaint, if needed.

Policy/Procedure	Steps to be taken by whom and when

Crisis Services

Note: Provide the names, locations and contact information for crisis services for children and families in the community. In addition, provide the LME's procedure for accessing these services.

Contact Information – Name, Relationship, Location	Crisis Plan – how to access services & supports and in what order

Funding of Services

Note: Document the programs and their funding that are available locally for specific circumstances. These are likely to be unique to the LEA and LME, but may also involve the local collaborative partners.

Program/Resource	What funding, for what purpose, process to access

Local Interagency System Operations

Note: Document here what action will be taken by whom when a problem arises about a particular child or about a procedure that is not working.

Community Partnerships

List here the contact information and location of meetings of the Local CFAC and the local collaborative as well as other opportunities for strengthening the community interaction.

Partnership/Advisory Meetings	**Contact and Meeting Information**

Action Steps:

Develop framework for agreement. (See examples of memorandum of agreement in the appendices.)

Sign and publish agreement for all stakeholders to see and use.

Signatures

LME Representatives Date

LEA Representatives Date

Other Representatives Date

Decisions about Local Operations

Benefits for LMEs, LEAs, Families and Communities

At the core of planning this transition are the families who want their children to be safe, healthy and successful in their homes, schools, at work and in life.

This transition offers an opportunity for an LME and each local school system in its catchment area to engage in meaningful community discussions. Together, LMEs and LEAs can develop a plan for operations regarding policies and procedures for use during this transition period and for the future. Although each local school system is autonomous and the agreements may differ from community to community, the steps to be taken are similar. These agreements offer improved outcomes and other benefits to all participants as shown below.

Operations Agreement	Investment Benefit to the LEA, LME & Community
Child & Family Teams	>Improve coordination and communication, one plan. >Establish shared outcomes and limited resources. >Build on strengths; identify what is working. >Improve family involvement, family choice - informed decision-making. >Support student assistance/services team goals. >Improve child and youth outcomes, e.g. increased attendance, achievement & end of year/grade completion & performance. >Reduce retention, disciplinary events, detention and suspension.
Shared Outcomes	>Share responsibilities to improve school performance and life functioning in the community. >Share limited resources to improve school success. >Strengthen family supports. >Coordinate providers and practices –reduces confusion, improves outcomes. >Invest in best practices to meet needs; what works.
Child/Youth & Family	>Share indicators for success – stays with family at home, stays in school, passing tests & grades, is healthy, gets needed help, builds on what child is good at, healthy peer/adult relationships, graduates, works, obtains higher education.

Rights and Responsibilities

With reference to the transition to Community Support services, local decisions and agreements must respect the rights of children and families as consumers of services and the responsibilities of agencies that provide education and mental health, developmental disabilities and substance abuse services.[8] While these rights and responsibilities are delineated from the state's perspective, local agencies may add to these lists.

[8] This is not intended to be an exhaustive list.

Children and families have rights to:

- Services in their community if at all possible.
- Attend a public school in their community.
- Choose a provider of MH/DD/SA services.
- Services that are safe.
- Confidentiality about their health and care.
- Grieve what they consider a wrong and to appeal a decision they don't agree with.
- Participate in the child and family team and in the development of a person-centered plan and crisis plan for their child.

Service providers have the responsibility to:

- Become endorsed by the LME to provide one or more services and to enroll with DMA prior to delivering those services.
- Hire qualified staff and ensure they are adequately trained.
- Demonstrate linguistic and cultural competence.
- Provide quality services.
- Meet requirements for working the school environment.
- Follow grievance and appeal procedures.

LMEs have responsibility to:

- Recruit and endorse and assist providers in their geographic area.
- Sign a performance contract with the DHHS.
- Follow federal and state statutes, rules and policies.
- Provide core services including uniform 24/7 access, screening, triage and referral and crisis services to all who request them.
- Follow procedures for the authorization of services.
- Manage state funding.
- Communicate with each LEA in their area about changes and collaborate on local operations.
- Communicate with all consumers and families and providers about transition to new service definitions and other changes.

LEAs have the responsibility to:

- Follow the directives of the local county school board.
- Exercise LEA autonomy.
- Provide educational services to all children.[9]
- Follow all federal & state requirements, statutes, rules, and guidelines such as No Child Left Behind, IDEA (including student assistance teams, individual education programs (IEP), positive behavioral supports, complaints & appeals), Safe Schools Act, cultural competence, etc.

[9] DPI Mission statement: North Carolina's public schools will create a system that will be customer-driven with local flexibility to achieve mastery of core skills with high levels of accountability in areas of student achievement.

- Development and implement IEPs, 504 and other plans for children who qualify.
- Provide educational opportunities for all students with an emphasis in improving achievement for all students and especially among minority and at-risk students.

Issues for Discussion and Agreement

There are many questions to answer, decisions to be made and agreements to be signed. This is an opportunity to create a thoughtful, planned transition to a new way of operating. One of the first questions to answer is who participates in what decisions and how decisions will be implemented.

The types of issues that must be addressed and how children and families, providers, LMEs and LEAs are affected are summarized in the following table. In brief, the issues focus on:

- Obtaining services for a child
- Provision of services in the school setting
- Crisis services
- Funding of services
- The local interagency system operation
- Community partnerships

The remainder of this workbook is organized by the types of issues identified above and in the following table. Each section discusses the issue and provides recommendations and reference to additional materials and examples of solutions that have proven to be successful in various communities. Factors that should be taken into consideration and the potential effects on stakeholders as decisions and agreements are made are also addressed in each section.

Recommended Items of Discussion regarding Issues

Issues	Child/Family	Providers	LME Staff	School Personnel
Obtaining services for a child	• Child & family team. • Person-centered plan (PCP). • Informed choice.	• Develop the PCP with child/family. • Participate in development of IEP. • Submit request for authorization of CS services.	• Screening/triage/ referral. • Endorse & monitor providers. • Target populations.	• Participate in child & family team and development of PCP. • Individual Education Program (IEP).
Provision of services	• Participate in authorized services from provider of choice. • Skill building (CS).	• Specialty training to work in school setting. • Confidentiality • Skill building (CS). • Agreement with LEA for working in school environment.	• Confidentiality. • Recommendations and possible training of school personnel (target populations, crisis services, PCPs, C&F teams, measures of system performance and outcomes for children, etc.). • Agreement with LEA for working in school environment.	• Agreements with LME and providers regarding services and procedures in school setting. • Confidentiality. • Recommendations and possible specialty training of providers (CS).
Crisis services	• Crisis plan & response. • Options for children/ families who are new to local LME system.	• First responder for child/family.	• Second responder for child/family. • Agreement with providers/LEAs on first response and other procedures.	• Agreement with providers/LME on first response and other procedures. • School crisis teams when available.
Funding of services	• Eligibility for Medicaid, Health Choice or other insurer	• Enrolled by DMA for Medicaid. • Billing for all insurers.	• Authorization of services. • State funded services.	• Federal funding of IDEA and other programs.
Local inter-agency system operation	• Participate in outcome and satisfaction measures. • Provide input to management.	• Collect and provide outcome data to LMEs. • Training.	• MOA with LEA. • Outcomes data. • Training.	• MOA with LME and providers. • Outcomes data. • Training.
Community partnerships	• Participate in community collaborative.	• Participate in community collaborative.	• Participate in community collaborative.	• Participate in community collaborative.

How a Child and Family Transition from CBS to CS

Transition to Community Support on March 20

The LME is responsible for communicating with providers and consumers and families about the upcoming changes in services and how transition will occur.

If a child and family are already receiving case management and/or CBS services through the LME and a provider, the new Community Support (CS) service must be authorized to begin on March 20 in order for services to continue without interruption.

In order for Community Support services to be authorized, several steps must take place.

1) The LME must endorse providers to deliver the service.
2) The child and family must choose a provider of CS services. The family may want or need assistance in choosing a provider, especially if both or neither of their current case management or CBS provider is among the choices. They might prefer a current provider. There might also be other factors for the family to take into consideration. For example, some school systems limit what providers can deliver services in the school environment.
3) Once the provider of CS is selected, the provider and family review the service plan and submit a request for authorization for the Community Support to begin on March 20.
4) Providers must be enrolled by DMA so they can bill for the services within a designated time period.

Developing or Updating the Person-Centered Plan

Within a year, by their annual review date (and preferably not to exceed the child's next birthday), the child and family and provider of Community Support must establish and work with the child and family team to develop the child's person-centered plan (PCP). The family will probably sign a consent form specifying who can participate on the child and family team and that they can share information among themselves to ensure delivery of services.

The Community Support provider is trained in guiding the family in developing a PCP that includes the family's strengths, goals and supports and all the services requested as needed for the child and family. The PCP also includes crisis and transition planning. Using the annual date as the timeframe for creating the PCP ensures that planning is completed for all children in a timely way. The provider of CS is then responsible for submitting the PCP for authorization of services. When services are authorized, the provider is responsible for notifying the family and providing them with a copy of the PCP.

The best interests of the child and family are served if a school representative participates on the child and family team. The school representative can bring educational information and evaluations to the team to assist in clarifying educational goals. If the student is identified as being a student with a disability at school, information about the student's evaluation and assessment and Individualized Education Program may be shared with parental permission.

Developing or Updating the Individual Education Program

If appropriate and the child qualifies, the LEA may develop an individualized education program (IEP) for a child. It is recommended that the school representative that participated in the development of the PCP and the Community Support provider participate along with the parent and school personnel in the development of the IEP to encourage consistency. If a child is not a special education student, but has a diagnosed mental health condition and access to education is being affected, the child may need a 504 plan. If a child is not eligible for an IEP or other services, the school staff, in conjunction with the parents, can develop an informal plan for that student.

If school personnel believe that a child may need services that are provided through the local management entity, they should meet with the parents or guardians of the child to express concern about the child and to urge them to seek help for the child. The school personnel may need to help the parents and guardians access the LME by providing phone numbers, location information and even providing transportation, if needed.

Federal and state laws require education agencies to locate, identify, and evaluate all children with disabilities who may be in need of special education and related services, including children who are enrolled in private or parochial elementary and secondary schools, or are being home schooled. A **referral** is a written request for an evaluation, which is given to the public school when a child is suspected of having a disability and might need special education services. After a child has been referred, an evaluation process must be followed to determine his/her need for special education services. **Evaluation** means *procedures used to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs.*

If a decision is made that a child with a disability needs special education and related services, an individualized education program (IEP) must be developed within thirty (30) days of that determination. An IEP is a written plan for the special education and/or related services that will be provided to a particular child. An IEP must be developed before special education and related services are provided to a child, and the services must start as soon as possible following the meeting(s) in which it was developed. The school is required to hold meetings at least once a year or more often if necessary, to review each child's IEP and to revise the IEP when needed.

Section 504 requires schools to provide to students with disabilities appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met. An appropriate education for a student with a disability under the Section 504 regulations could consist of education in regular classrooms, education in regular classes with supplementary services, and/or special education and related services. Schools must develop plans to assist the students in receiving a free and appropriate education.

Decisions

Document on the worksheet the agreements for steps to be taken by who and by when, regarding:

- Communication with providers about endorsement and enrollment.
- Communications with families about choosing a provider.
- Updating the current service plan and requesting authorization of Community Support services for March 20.
- Child and family team and development of the PCP.
- Update or development of the IEP or other educational plan.

Provision of Services

Provision of Community Support Services

As described in the introduction, Community Support is focused on skill building for the student and family. Two main tasks in working with the child and family are to establish the child and family team and to develop the person-centered plan for the child and family. A provider who chooses to provide Community Support services must first be endorsed by the LME. Endorsement is a verification and quality assurance process that indicates that the provider meets the requirements and qualifications for the service as stated in the service definitions. While initially a provider can be conditionally endorsed, the provider must meet full endorsement to provide the service by June 30, 2007.[10]

Child & Family Teams

A child and family team is a group of people that meets with a child and family to set goals and plan services. The team is built around the family to make sure that the family's strengths are promoted and their needs are met. Team members work together with the family to write the person-centered plan based on what the child/youth and family wants and needs.

The family is always part of the CFT. Children who are old enough to attend meetings, understand the process, and make choices can attend. Otherwise, the team can include anyone who is important in the family's life and who knows its strengths and needs. Team members are usually people who are part of your child's education, care, custody, or treatment, and others who know your family and lend support, including other family members, friends and neighbors, members of a business or church, teachers and other school staff, family advocates, doctors, social workers, case managers, court counselors as well as providers of MH/DD/SA services.[11]

Person-Centered Planning

A person-centered plan is a written plan that clearly states for everyone assisting the child and family what is needed, what is expected and who will do each part. It lists the people and agencies that will work with the child and family. It spells out what people will do and how, where, and when they will help. It always includes a detailed crisis plan and may include a transition plan, if appropriate.[12]

Person-centered planning is fundamental to determining the child and family's real life outcomes. It documents the strategies to achieve those outcomes. The key values and essential elements of any person-centered plan are defined in the DMH/DD/SAS Communication Bulletin #34 (March

[10] See a full explanation of endorsement in a memorandum and attachments dated 1/6/06 on the DMH/DD/SAS web site at: http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.
[11] See the *North Carolina System of Care Handbook for Children, Youth and Families*, 2005, prepared by the NC Families United, Inc.
[12] A transition plan clarifies the process for assisting the child and family in a process of change, for example, as the child moves between services, between residential settings (such as from state hospital to community), or into adulthood.

2005) along with documentation elements and indicators to demonstrate that person-centered planning has occurred.

Interventions for Children with Behavioral-Emotional Disabilities through the School System

There are a variety of interventions that may be provided through the school system for children with behavioral – emotional disabilities, including psycho/social interventions, educational interventions and traditional interventions that may be provided through the school system. See appendix G for a list and description of these interventions.

General education teachers should be sensitized to:

- Characteristics of children that may indicate behavioral-emotional disabilities.
- Ranges of normal behavior relative to respective developmental levels of students.
- Potential ramifications of a student acquiring the label of behavioral-emotional disabled.

Efforts to provide such an awareness and information through in-service training or other methods should diminish the potential for premature or unnecessary concerns.

Individuals with Disabilities Education Improvement Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) (formerly called P.L. 94-142 or the Education for all Handicapped Children Act of 1975) requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment appropriate to their individual needs.

IDEA requires public school systems to develop appropriate Individualized Education Programs (IEP's) for each child. The specific special education and related services outlined in each IEP reflect the individualized needs of each student.

IDEA also mandates that particular procedures be followed in the development of the IEP. Each student's IEP must be developed by a team of knowledgeable persons and must be at least reviewed annually. The team includes the child's teacher; the parents, subject to certain limited exceptions; the child, if determined appropriate; an agency representative who is qualified to provide or supervise the provision of special education; and other individuals at the parents' or agency's discretion. More information can be found in appendix I.

Provision of Community Support Services in the School Environment

The primary focus here is an agreement among the LEA and individual schools with providers of Community Support and the LME. In addition to ensuring that children receive an adequate education including special education and related school services, the LEA may collaborate with the LME and providers of Community Support and other services to enable children to receive mental health and substance abuse services that they require and qualify for.

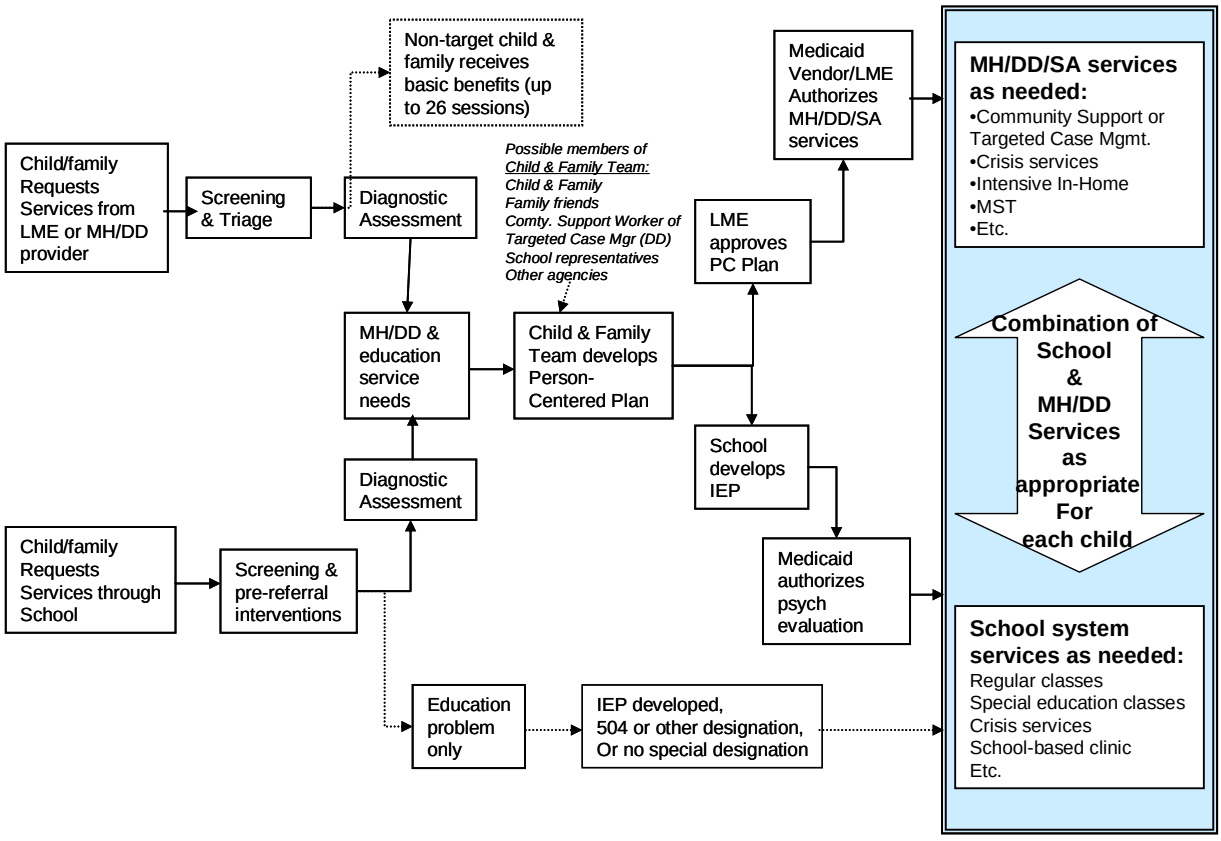
In the past, local experience has ranged from having no CBS services provided in the school environment, to LEAs who limited the number of providers who could enter the school environment, to having a general agreement between a school and providers on procedures for

providing a service on school property, to having no agreement at all. One issue raised by school representatives in the past has been having too many unknown CBS workers on school property that were not aware of or were insensitive to school policies and practices (like positive behavioral support).

LEAs have requested guidance from LMEs on how to use the Community Support model. These kinds of issues can be resolved through the development of working relationships among LMEs, providers and LEAs, as well as the children and families involved. There are many alternatives for agreements and they will be tailored to each LEA. See alternative models in appendix H.

Regardless of the decisions made, the procedures for the provision of community support services in the school environment must be communicated with children/families. Additional information can be found in the parent handbook on the DPI, Exceptional Children Division web page. See: http://www.dpi.state.nc.us/ec/policy/resources/rights

Interagency Services for Children with Educational & MH/DD Service Needs



Decisions

Document on the worksheet the agreements for steps to be taken by who and by when, regarding the following and other decisions:

- Qualifications of providers including specialty training to work in school setting.
- Communication with child/families about what services will entail including skill building.
- Maintenance of confidentiality.
- Agreement with LEA about procedures for working in the school environment.

Crisis Services

Another issue that LMEs, LEAs and providers need to discuss is how to respond when a child experiences a crisis at school. As in any crisis, it is important to remember that the crisis is the child's perception of and response to a stressful situation, not the situation itself. Crisis intervention is a service or support that is aimed at helping the child manage the crisis safely and return to his or her regular life.

Currently, some schools or LEAs have a school crisis team or other plan for responding to crises. Currently, many families do not have an adequate crisis plan for their children or one that involves their current providers. Even for those families with a crisis plan, if the situation occurs at school, school personnel may not be aware of a particular child's plan. Everyone agrees that "call 911" is not an adequate crisis plan.

Clearly, this is an issue that can have strong impact on children, families, schools, providers and communities and is essential for discussion. If a child is likely to have a crisis at school, it is important to know how to prevent the crisis and how to handle it. This should be included in a behavioral intervention plan and person-centered plan for that child. The plan should include strategies and supports that work for that specific child, as well as who needs to be contacted for assistance.

Crisis Planning

Currently, the IEP team may develop a crisis plan for a child who is a student with a disability. Best practice would be to develop such a plan for every child who may have a crisis at school. The Community Support providers and representatives of the LME must be involved in the development of that crisis plan if they are a responder to the crisis. School personnel, providers and the LME must have a list of people to contact in the event of a crisis.

Here again, the participation of the school personnel on the child and family team and the participation of the Community Support provider on the IEP team will facilitate this joint planning. The child's crisis plan should include the services for exceptional children provided by the school.

Also, the development of a person-centered plan for a child and family includes the development of the crisis plan including the school's crisis plan. The child and family team should carefully lay out a crisis plan that includes:

- A description of warning signs or triggers of a crisis for the child.
- What a teacher or provider or parent can do to help the child and family avoid a crisis.
- Who will act and what they will do if a child does experience a crisis.

The crisis plan should be very practical and easy to understand. It should be easily accessible to the family, the provider, the LME, and school personnel. It should be followed, assuming it is defined as it is for good reason.

Provision of MH/DD/SA emergency response

A core responsibility of an LME is for responding to emergencies within 2 hours of contact for anyone in the community. LMEs are building and evaluating the network of local and regional emergency services including 24/7/365 screening and referral, accessing the emergency room at the local hospital, dispatching mobile crisis units, or authorizing use of a state psychiatric hospital, if necessary.

One of the requirements of the Community Support service definition is the provider is the first responder in case of crisis for a child and family they serve. However, until each child has a person-centered plan and crisis plan, the LEA, LME, providers and families must agree on how such crises will be handled. That is, what actions will be taken by whom in what capacity and when.

Decisions

Document on the worksheet the following:

- Communication with LME and providers if a child experiences a crisis at school.
- Joint crisis planning with family, school and provider.
- How the school crisis team or other school personnel will work with the provider/LME.
- Crisis response is a child by child decision or one response for all children?
- How will confidentiality be maintained?
- If a child has a history of aggression, will the crisis plan include restraint as an option.
- How will crisis plans be monitored and updated.

Funding of Services

LME

Most often, children served by the local MH/DD/SA services system and their families are eligible for Medicaid, while some families are eligible for Health Choice or other insurers. State and federal funding for children and families who are not eligible for Medicaid is unfortunately very limited and is not an entitlement as Medicaid.

LEA

Federal funds for special education students are allocated based on a formula that takes into account the population and poverty level. Funds are not allocated on a child by child basis and not every child with a MH/DD/SA designation gets an IEP. There are also state funds for special education which are allocated to each school system. In addition the school system has the opportunity to apply for other special education funds that can support students with unexpected needs. Special education staff in the LEA should be aware of these funds. Some of these funding opportunities are listed below.

Capacity Building and Improvement Grant (SLIVER)

Allows states to use the excess of inflation in any year to be used for subgrants to local education agencies, state-operated programs, charter schools or Department of Corrections for Capacity Building and Improvement.

Developmental Day Center Program (DDC)

Assists local education agencies in providing special education and related services to eligible children with disabilities served in certified developmental day centers.

Group/Foster Home Program (GFH)

Reimburses local education agencies that provide educational services to eligible children with disabilities residing in group and foster homes and not counted in the regular, state, and federal child counts.

Individuals with Disabilities Education Act (IDEA, Part B)

To demonstrate eligibility via procedures to receive grant awards under 611 and 619 of the Individuals with Disabilities Education Act (IDEA).

Risk Pool Program

To demonstrate eligibility via procedures to receive grant awards under Program Report Code (PRC114) of the Individuals with Disabilities Improvement Act of 2004 (IDEA).

Out-Of-District Placement Program (OOD)

Reimburses local education agencies for educational services provided to eligible children with disabilities served in out-of-district school settings.

Special State Reserve Funds (SSRF)

A reserve is established to use when all available state, federal and local resources have been exhausted. They are to be used for emergency situations, such as high-cost children or severely disabled children.

PRC 29 – Behavioral Support Services Funding

A special budget provision in the 1999 Appropriation Act modified the use of the state dollars in PRC 29 to allow expenditure of these funds to provide services to "(i) children with special needs who were identified as members of the Willie M. class at the time of dissolution of the class, and (ii) other children with special needs." This provision provides the flexibility to use these funds for services for other children with special needs who have significant behavioral and emotional needs in the public schools.

The purposes of these funds are to provide resources for services that are specific to the individual needs of the targeted population and that enhance the service delivery capacity of the receiving LEA to appropriately serve students with more severe and complex behavioral-emotional needs. These allocations are made available through a competitive needs-based grant process. The state resources made available for funding these LEA grants are fixed, and; therefore, funding requests may be denied or partially funded by the Department. LEAs submit their budget requests each year by May 1. All funds are allocated each year.

Decisions

In addition to the funding sources described above, there may also be local funding available for specific circumstances. These are likely to be unique to a county, but may also involve the local collaborative partners.

- Document what sources of funding are available and for what purpose and how they can be accessed.

Local Interagency System Operations

Memorandum of Agreement or Understanding

MOAs and MOUs are tools that are successfully used by LEAs and LMEs and providers to document clearly responsibilities and procedures for interagency operation. Several are shown in appendix H. Topics that might be covered in the MOA or MOU are procedures for accessing services, participation on the child and family team and the IEP team, confidentiality, training, sharing of data, and monitoring the effectiveness of the agreements.

Outcomes and Monitoring the Effectiveness of the System

One of the subjects for discussion is how the LME and LEA will determine the effectiveness of their agreement. The following are suggested for consideration including sharing of outcomes data to track success for individual children and for the system as a whole.

1. Ways to demonstrate success for all children - use population-based data by LEA, by county, by LME, by state.

2. Outcomes – remaining in school, academic progress, behavioral progress system wide (# suspensions, academic progress, # MH/DD/SA workers in schools, disruptions in classrooms, etc.)

3. Ways to demonstrate effects of transition to new services and new agreements among LMEs, providers, LEAs (compare Spring 2005, Fall 2005, Spring 2006 and Fall 2006 and Spring 2007) and compare to SAMHSA 1st school MH services survey.

4. Parental perception/ satisfaction with services before and after transition

5. Suggest measures/means of collecting & compiling data for local & statewide comparisons

Training and Technical Assistance for Providers

Community Support providers are required to take 20 hours of training including training in service definitions, person-centered planning, and crisis planning and prevention. The LME and provider and LEA could consider cross training of staff to increase their interagency collaboration.

Community Partnerships

As the LME, LEA, providers and families collaborate on the delivery and coordination of MH/DD/SA services and LEA education services, their participation in the local community collaborative can be most effective for other agencies as well. As community partners they can contribute to discussions about problems, gaps in services, special needs and procedures.

Decision

Document on the worksheet the meeting dates, times and contacts for community collaboratives and other such interagency and community groups.

Appendices

A. Reform of MH/DD/SA Services
B. Questions and Answers about Community Support Services
C. Map of LME Catchment Areas
D. Map of LEAs and Behavioral Support Section Assignments
E. Letters from DPI and DMH/DD/SAS Regarding New Services
F. LME and LEA and Regional Contacts
G. Interventions for Children with Behavioral-Emotional Disabilities through the School System
H. Sample Local Solutions
I. Resources to Assist Parents and Family Members
J. Acronyms
K. Glossary
L. Text from DVD Presentation

Appendix A. Reform of MH/DD/SA Services

Reform of the public MH/DD/SAS system as specified in Session Law 2001-437 requires the North Carolina Department of Health and Human Services (DHHS) to focus the state's limited resources for individuals who are the most severely disabled and to provide best practice models of care for these individuals in communities of their choice. Therefore, the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) established specific target populations for adult mental health, child mental health, developmental disabilities and substance abuse.

The reform legislation also requires the publication of an annual state plan that outlines the mission and vision of the division, its organizational structure, protection of client rights, involvement of consumers in planning and management of their services, uniform access to services, core services as well as basic and enhanced services, intersystem collaboration, and outcome based monitoring of the system.[25]

Core Services, Enhanced Services and Basic Benefits

Anyone is eligible for core services of the public mh/dd/sa system. Access is available 24 hours a day, seven days a week. The local management entity (LME) provides screening and triage to determine in the individual's needs are emergent, urgent or routine, and then refers the individual for appropriate services. If the situation is emergent, the goal is to resolve the crisis/situation in a proactive and supportive way that engages the consumer, family or other support persons and ultimately engages the person into services.

If the needs are not emergent, there is a determination if the individual is a member of a target population. If the person is not a member of a target population, the system will typically provide basic benefits – services that are less intensive and shorter in duration.

If the person is a member of a target population, the system will usually provide enhanced services, supports, treatment and/or care that are more comprehensive, intensive and of longer duration.[26] The enhanced benefit service definition package is for persons with complicated service needs beginning with the first contact with a provider. Initial treatment or service occurs at the time a diagnostic assessment is ordered and the person-centered planning begins. Persons who do not qualify for a target population but are eligible for Medicaid and meets "medical necessity" for covered mh/dd/sa services are entitled to basic services.

[25] The annual state plans can be found on the division's web site: http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.htm

[26] It is important to note that anyone who is part of a target population can receive services through the public mh/dd/sa system. However, if not eligible for Medicaid, the provision of services is not an entitlement. Thus, the publicly sponsored system is challenged with managing available resources to meet the needs of these priority populations.

Person-Centered Planning

Person-centered planning is fundamental to determining real life outcomes and developing strategies to achieve those outcomes for children and their families. The key values and essential elements of any person-centered plan are defined in the Division's Communication Bulletin #34 (March 2005).

Evidence Based, Emerging and Promising Practices

State Plan 2003 identified three primary values for transforming the system: (1) investing for results, (2) "no wrong door" to services and supports, and (3) commitment to quality. These values require focus on the content and quality of the services and supports offered. That focus requires adherence to evidence based practices and fidelity to specific program models that are shown to produce consistently cost effective results.

MH/DD/SAS Child Target Populations

As required by the reform legislation, appropriate criteria were selected to identify children and adolescents with the greatest needs including both diagnostic and functional elements as well as circumstances unique to each person. Children who are eligible for enhanced services are described below.

Children with Mental Health Disorders

Approximately 10 to 12 percent of the state's children experience serious emotional disturbance (SED). Based on the projected population of children aged 17 and younger for 2003, between 205,137 and 246,164 North Carolina children experience SED. The estimates adjusted for percent in poverty are based on a methodology established by a panel of experts convened by the federal Center for Mental Health Services.[27]

Children with Developmental Disabilities

The Division's developmental disabilities services follow recommendations of the National Association of State Directors of Developmental Disabilities Services and use the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. This means that there are approximately 130,810 people in NC with developmental disabilities.

Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language,

[27] Federal Register, 1998.

capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

Child and Adolescent Substance Abuse

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children and youth under age 21 can be kept from smoking cigarettes, using illicit drugs and abusing alcohol, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return.[28] As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

Priorities within the child and adolescent substance abuse target populations include:

- Adolescent pregnant injecting drug users.
- Adolescent pregnant substance abusers.
- Adolescent injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Child clients who have co-occurring physical disabilities.
- Child homeless clients.
- All others within the target populations.

[28] All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Appendix B. Questions & Answers about Community Support[29]

Who are the target populations for Community Support services?

The people served by Community Support service are those with substance abuse and/or mental health diagnosis. Different service options are being developed for individuals with developmental disabilities.

Is Community Support the same as CBS?

No. Community Support includes case management and individual support and focuses on skill building for the child, family and others who are involved in the child's life.

Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.

The service activities of Community Support consist of a variety of interventions:
- identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community;
- family psychoeducation development and revision of the recipient's person-centered plan;
- and one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to home, school, and work environments; therapeutic mentoring; symptom monitoring; monitoring medications; and self management of symptoms.

What can the community support worker do?

These activities reflect the appropriate scope of duties for the Associate Professionals and Paraprofessionals:

• Various skill building activities.
• Training of the caregiver.
• Daily and community living skills.
• Socialization skills.
• Adaptation skills.
• Development of leisure time.

Interests/Activities
• Symptom monitoring and management skills.
• Therapeutic mentoring.
• Education substance abuse.
• Behavior and anger management.

What does the Qualified Professional do?

[29] See the DMH/DD/SAS web site for the complete service definition of Community Support – Children/Adolescents at: http://www.dhhs.state.nc.us/mhddsas/

These activities reflect the appropriate scope of duties for the Associate Professionals

- Coordination and oversight of initial and ongoing assessment activities.
- Initial development and ongoing revision of the person-centered plan.
- Monitoring of implementation of person-centered plan.
- Additional case management functions of linking, arranging for services and referrals.

Where can Community Supports services be conducted?

Community Support services are provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc.

What kind of training does the Community Services worker receive?

All staff providing community support to adults must complete a minimum of twenty (20) hours of training specific to the required components of the community support service definition including crisis response within the first 90 days of employment.

Will each person getting Community Support Services have their own workers?

Community Support services may be provided to groups of individuals. When Community Support services are provided in a group, groups may not exceed eight (8) individuals.

Appendix C. Actual and Proposed Local Management Entities (LMEs) as of September 2005

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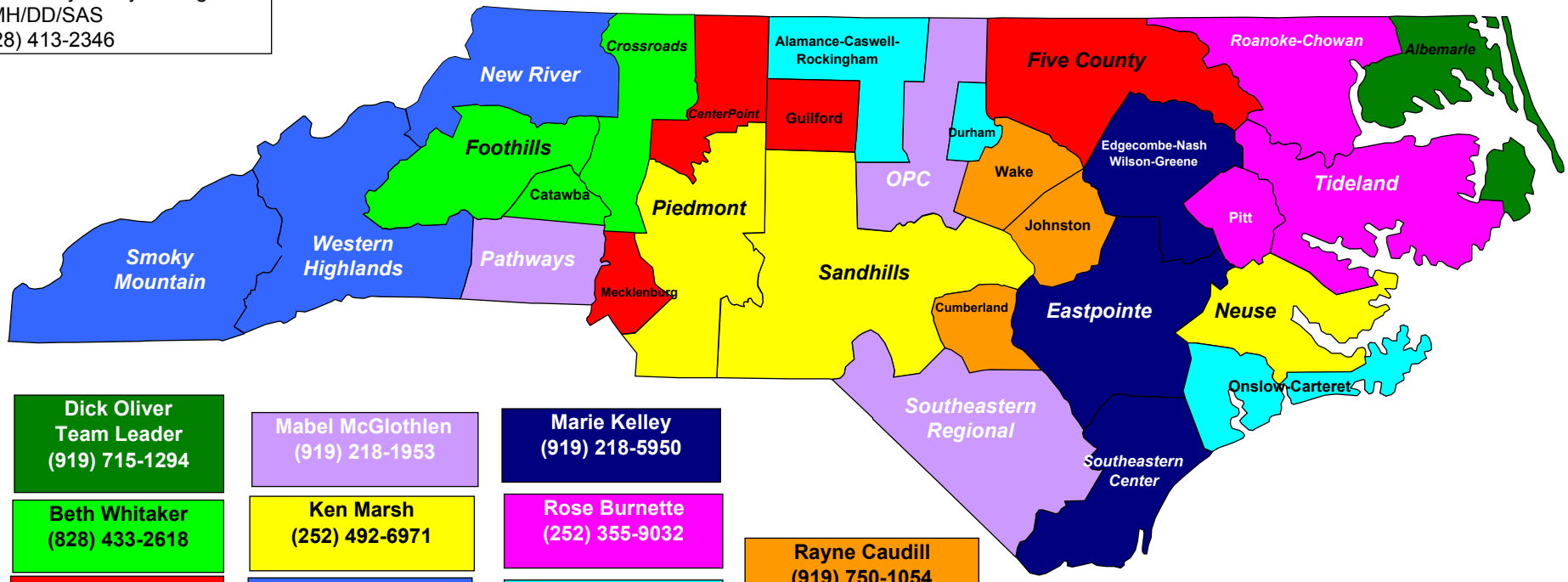

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Appendix D. North Carolina
Behavioral Support Section: LEA Assignments

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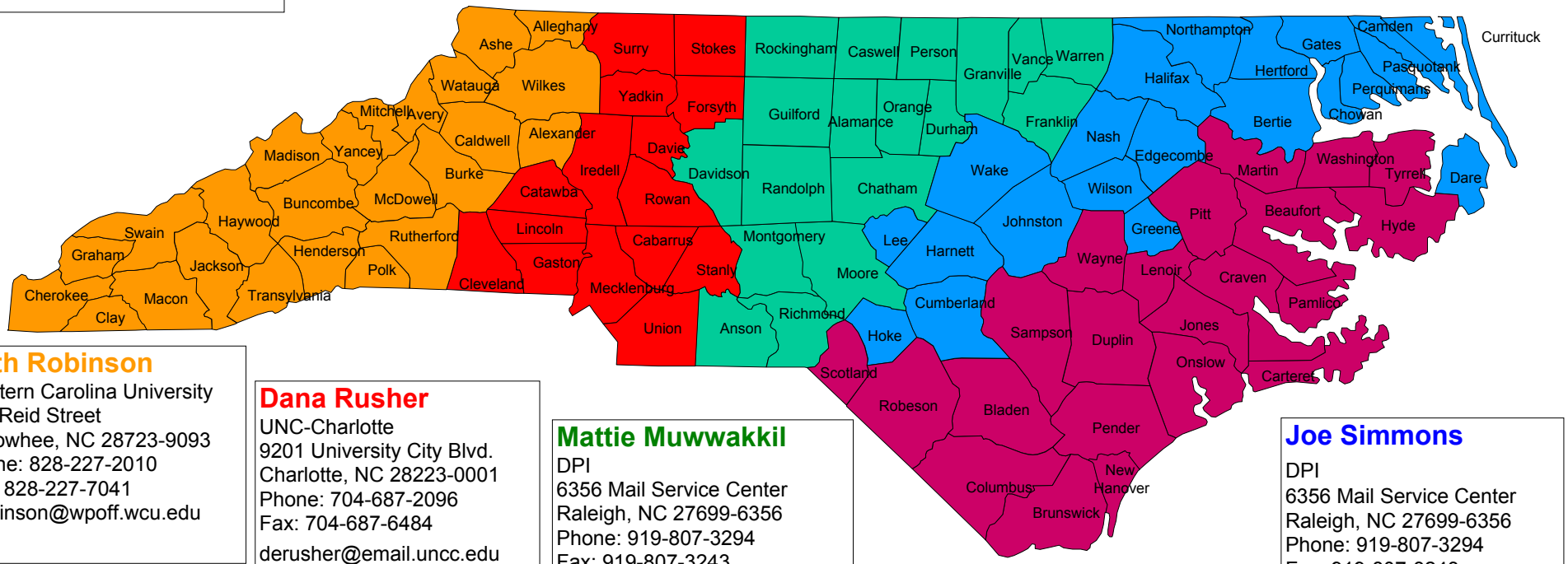

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Appendix E.

Memorandum from Allen Dobson, MD, DMA and Mike Moseley, DMH/DD/SAS dated January 19, 2006

Memorandum from Mary N. Watson, Director of Exceptional Children Division, DPI, dated January 20, 2006

Memorandum from Allen Dobson, MD, DMA and Mike Moseley, DMH/DD/SAS dated February 2, 2006

North Carolina Department of Health and Human Services

Michael F. Easley, Governor — Carmen Hooker Odom, Secretary

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L. Allen Dobson, Jr MD, Assistant Secretary for Health Policy and Medical Assistance

January 19, 2006

MEMORANDUM

TO: Legislative Oversight Committee Members
Commission for MH/DD/SAS
Consumer/Family Advisory Committee Chairs
State Consumer Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

FROM: Allen Dobson, MD
Mike Moseley

SUBJECT: Enhanced Services Implementation

The federal Centers for Medicare and Medicaid Services (CMS) has approved our Medicaid State Plan Amendment (SPA) to implement the Enhanced Benefit Services we proposed under the Rehabilitation Option. The final, approved version of the service definitions is available on the DMH/DD/SAS website at http://www.dhhs.state.nc.us/mhddsas. **These new services become effective Monday, March 20, 2006.** Outlined below are our plans for dealing with some important initial transition and implementation issues.

Person Centered Plans

As we work to make our system more consumer-focused and outcome-driven, one of the key changes we are making is the implementation of Person Centered Planning for all people with significant mental health, developmental disabilities and substance abuse services issues. All of the new services to be implemented on

March 20, 2006 require the development of a Person Centered Plan (PCP). Person Centered Planning takes a strengths-based approach to identifying the services and supports that may be medically necessary to assist individuals in achieving their goals and objectives. Person Centered Planning puts consumers and their families in charge of defining the direction of their lives.

The development of a full PCP takes a considerable amount of time. A full PCP includes information on the natural and community supports to which a consumer has access to help achieve his/her goals, a crisis plan that outlines in advance the actions that will take place if the consumer experiences a crisis, and an individualized treatment plan that outlines the paid services and supports the consumer will receive. We recognize that there is not sufficient time prior to the implementation of the new services for all consumers to work with a clinician of their choice to develop a full PCP. In order to ensure that consumers continue to receive needed services during the implementation phase, the following transition plan has been developed:

1. DMA and DMH/DD/SAS will publish a crosswalk of old services to new services. If the services a consumer will receive at implementation crosswalks to the services they currently receive and the authorized number of units is unchanged, the clinician may just note the change in service name on the treatment plan and sign and date the plan.
2. If a consumer is currently receiving more than one service and the new service definitions contain an exclusion that prohibits any of the services they are currently receiving to be delivered concurrently, the clinician may simply note on the treatment plan the service(s) to be removed and note that the removal is due to service exclusions, sign and date the plan. [Note: this process only speaks to quickly adjusting the treatment plan. Medicaid eligible consumers are entitled to due process rights. Medicaid eligible consumers must receive a formal notification, including notification of their appeal rights, for any services that Medicaid continues to cover that are removed from the plan through this procedure. See the discussion of due process notices later in this document.]
3. If a consumer will receive a new service that does not crosswalk from an existing service, a full PCP must be developed. If a consumer accesses a new enhanced benefit after the implementation of the new services definitions, a full PCP will need to be developed within the first 30 days of service.
4. All consumers currently receiving services, whose treatment plan component is adjusted at implementation in accordance with paragraphs 1 and 2 above but receive no other new services, will work with a clinician in the month of their next birthday to develop a full PCP.

Provider Endorsement/Enrollment

In addition to significantly expanding and improving the service continuum available to consumers with mental health and substance abuse issues, this SPA also expands direct enrollment into the Medicaid program to all providers of Rehabilitation Option services. Providers will be enrolled in Medicaid as Community Intervention Service providers. Once providers are enrolled, they will directly bill Medicaid for all authorized Medicaid covered services they deliver to Medicaid eligible consumers. We have established a process through which Local Management Entities (LMEs), acting on behalf of DMA, will review the proposed provider's staffing and compliance with the service definitions and endorse the provider, if they meet requirements, for enrollment in the Medicaid program. At the time of implementation, all providers meeting requirements will receive a conditional endorsement until they have actual experience in delivering the new services as defined by the new service definition. Please see DMH/DD/SAS Communication Bulletin #44 (http://www.dhhs.state.nc.us/mhddsas/announce/index.htm) for the full policy and procedures on endorsement.

We are very pleased that none of the changes we negotiated with CMS to reach approval of the SPA have affected the endorsement process; the provider qualifications, training and staffing requirements, etc. are all as we initially proposed them. Providers who have already been through the endorsement process and were given a letter indicating their endorsement was approved subject to any changes made by CMS are now eligible for conditional endorsement. Providers wishing to enroll with Medicaid should complete the Medicaid enrollment package (http://www.dhhs.state.nc.us/dma/Forms/provenroll/cis.htm) and submit it along with all required documentation and a copy of the LME endorsement letter to DMA Provider Services.

In order to implement this change in as orderly a fashion as possible, we have developed a phase-in plan for provider endorsement. Please see Communication Bulletin # 47, Provider Endorsement Transition Plan at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm. Providers wishing to deliver services outlined in the first two phases of endorsement should be actively pursing endorsement and enrollment. **Providers' enrollment for these first two phases will become effective on March 20, 2006 or the first day of the month in which the completed provider application package and all required document is received by DMA, whichever is later.** Please note that the changes necessary in the provider billing and information system to permit enrollment of providers of these new services are currently being made and it may be several weeks before providers will actually receive provider numbers.

DMA and DMH/DD/SAS are committed to processing endorsements and enrollments as expeditiously as possible. But, we may experience some delay in view of the anticipated volume of requests. To ensure that providers currently delivering services do not experience unnecessary cash flow delays, we have agreed that providers currently delivering services under contract to a LME may continue to bill through the LME for services included in the first two phases of endorsement that are delivered on or before May 31, 2006 if their endorsement/enrollment application is in process but they have not received notification of their new Medicaid provider number. In subsequent transition phases, billing will be permitted for services delivered up to 30 days following the end of the phase.

LMEs wishing to directly provide Medicaid services must also be endorsed by DHHS and enrolled as Community Intervention Services provider. Prior to endorsement, the LME must receive a waiver from the Secretary in order to provide services. A copy of the Secretary's waiver shall be included in the application package submitted to DMA Provider Enrollment Section. Instructions for obtaining the waiver to provide services by a LME have been sent out previously under separate cover.

Subjects for Future Updates:

Due Process Issues

As noted earlier in this correspondence, many Medicaid eligible consumers will need to receive formal notification of service changes and their associated appeal rights as a result of implementation of the new services. We will distribute to LMEs and providers in the next few weeks a standardized letter to be used in those required notices.

Developmental Disabilities

CMS did not approve our proposed enhanced service for people with developmental disabilities that was designed to replace the existing service, Community Based Services (CBS). We are committed to ensuring that all people with developmental disabilities currently receiving CBS are able to access needed service through existing programs. We will publish additional information about our proposed strategy and plan very shortly.

Communications

We are planning a teleconference for late January or early February to discuss implementation plans and issues. Additional information on that event will be published as soon as the date is finalized. In addition, it is our plan to continue to provide written updates such as Question and Answer Documents (Q & A) on a regular basis.

Training

We are aware of the need for additional training in services, basic Medicaid billing, other Medicaid covered services and more specifically how to obtain the 20 hours of required training per service. We will provide more guidance on all areas of training in the near future.

Thank you for your efforts on behalf of people with disabilities. The implementation of the new services represents a whole new phase in our efforts to transform our public MH/DD/SA system. Our staff are committed to working with you to assure a smooth transition. We know that the next few months will be challenging, but we hope you will agree with us that it is also tremendously exciting to be finally implementing these new best practice services that we have discussed for so long.

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMH/DD/SAS Staff
Rob Lamme
Rich Slipsky
Wayne Williams
Kaye Holder
Coalition 2001 Chair
Mark Benton
Dr. William Lawrence
Tara Larson
Carol Robertson
Angela Floyd

PUBLIC SCHOOLS OF NORTH CAROLINA
STATE BOARD OF EDUCATION Howard N. Lee, *Chairman*
DEPARTMENT OF PUBLIC INSTRUCTION June St. Clair Atkinson, Ed.D., *State Superintendent*
WWW.NCPUBLICSCHOOLS.ORG

January 20, 2006

MEMORANDUM

To: Directors, Exceptional Children Programs
Directors, Charter Schools

From: Mary N. Watson, Director
Exceptional Children Division

Subject: DHHS Service Definition Changes Begin March 20

The Department of Health and Human Services (DHHS) has new service definitions for mental health, developmental disabilities and substance abuse services that will go into affect on March 20. Notification about service definition approval came to DHHS in late December, 2005. These service definition changes will have implications for all students in public schools who receive mental health, developmental disability or substance abuse services in school provided by private providers and paid for by Medicaid or a funding stream of the Local Management Entity (LME). It is important that schools, LMEs, private providers and families work together to insure that students still receive the supports they need to be successful at school.

DHHS has indicated that 670 students in schools in North Carolina who are diagnosed as developmentally delayed without a second diagnosis of mental illness will no longer qualify for a CBS/CS worker under the new service definitions. The new definition for developmental therapy submitted by North Carolina was denied by the federal agency. These students are likely to be identified as students with autism, mental disabilities or severe and profound disabilities for special education services. It is very important that the Individual Education Program Teams for these 670 students meet to be sure that supports and services are in place when a CBS worker is no longer available on March 20. Local school systems must identify the students that will be affected and create the appropriate plans for these students.

Additional information will be available in early March from LMEs to help schools and school systems develop plans for the transition of services provided to other students affected by the change in service definitions. The LMEs will invite your school system to send representatives to a meeting concerning this issue. It is anticipated that for all other student groups, there will not be an abrupt change in services. These changes will be more gradual and should involve joint planning between schools, LMEs, private providers and families.

EXCEPTIONAL CHILDREN DIVISION
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If you have questions about this memo, please contact Diann Irwin, 919-807-3298 or dirwin@dpi.state.nc.us Through collaboration between schools, agencies, providers and families, the needed supports can be provided for all students.

MNW/di

c. Elsie Leak, Associate Superintendent
Janice Davis, Deputy Superintendent
Exceptional Children Division

North Carolina Department of Health and Human Services

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
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Michael Moseley, Director

Division of Medical Assistance

2501 Mail Service Center
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Tel 919-857-4011• Fax 919-733-6608
L. Allen Dobson, Jr. MD, Assistant Secretary for Health Policy and Medical Assistance

February 2, 2006

MEMORANDUM

TO: Legislative Oversight Committee Members
Commission for MH/DD/SAS
Consumer/Family Advisory Committee Chairs
State Consumer Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Board Chairs
North Carolina Council of Community Programs
State Facility Directors
Area Program Directors
Area Program Board Chairs
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

FROM: Allen Dobson, MD LADmb

Mike Moseley

SUBJECT: Enhanced Services Implementation Update # 2
Medicaid-Eligible Consumers with Developmental Disabilities Receiving CBS

The federal Centers for Medicare and Medicaid Services (CMS) has required the Department of Health and Human Services (DHHS) to eliminate the service known as Community Based Service (CBS) from North Carolina's Medicaid State Plan upon implementation of the new Enhanced Benefit services. As you know, they also refused to approve the service that was designed to replace CBS for people with developmental disabilities. These unfortunate federal decisions has forced the Department to identify alternative strategies for continuing to support people with developmental disabilities in the community. The following transition plan has been developed with the collaboration and input from key stakeholders, consumers and families.

Prioritized Alternatives

Five strategies have been developed to address the needs of Medicaid-eligible DD consumers receiving CBS. Please note that although CMS would not approve Developmental Therapy as a Medicaid covered service, it will be a covered service (funded exclusively with state funds) for people with DD in the target population whose CBS services are currently funded by state or federal funds administered by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). Therefore, non-Medicaid eligible people with DD currently receiving CBS will automatically transition to Developmental Therapy in accordance with the crosswalk process outlined in the Person Centered Planning section of our January 19, 2006 memorandum.

The five strategies for Medicaid-eligible consumers, in preferred order, are:

1. Individual is currently receiving CBS in addition to CAP-MR/DD waiver services – amend CAP-MR/DD Plan of Care (POC) to add additional waiver services, as necessary, to replace CBS.
2. Individual is not currently receiving CAP-MR/DD waiver services but appears to meet the ICF/MR Level of Care (LOC) criteria – process MR2 and supporting documents to qualify the individual for waiver participation
3. Individual does not meet ICF/MR LOC and is receiving CBS primarily due to mental health/substance abuse/behavioral issues – crosswalk to the new service of Community Support.
4. Individual does not meet ICF/MR LOC and is receiving CBS primarily due to DD issues – refer to a home care or home health agency for assessment for Medicaid Personal Care Services.
5. Individual does not meet ICF/MR LOC, is receiving CBS primarily due to DD issues, and Medicaid Personal Care Services will not address the individual's full treatment needs or the individual does not meet eligibility criteria for Medicaid Personal Care Services – authorize state-funded Developmental Therapy services in accordance with utilization review guidelines issued by DMH/DD/SAS.

Case managers should immediately begin conducting individual reviews with all developmentally disabled consumers on their caseload who are Medicaid-eligible and are receiving CBS. Following the priority order outlined above, and in accordance with the additional guidance which follows, case managers and consumers should identify and immediately take action to implement the strategy that is appropriate for each consumer.

CAP-MR/DD Waiver

DMH/DD/SAS and the Division of Medical Assistance (DMA) have submitted a technical amendment to the CAP-MR/DD Waiver to increase the number of people by two-thousand (2,000) that can be served by the waiver. We do not anticipate any difficulty in receiving prompt approval from CMS for this technical amendment.

DMH/DD/SAS will provide LMEs with information on the projected increase in the CAP-MR/DD Virtual Allocation and numbers of additional people to be served by Friday, February 10, 2006. LMEs will work with case managers to expeditiously process revised POCs for individuals in category 1, above, and to process applications for waiver participation for individuals in category 2. **In order to address this emergency situation created by the CMS decision, regardless of the plan or process that a LME has developed to prioritize the use of waiver funding allocations, the only people that shall be added to the waiver at this time are Medicaid eligible consumers currently receiving CBS.**

The DMH/DD/SAS State Operated Services Section has worked with Murdoch Center to identify additional resources to increase the capacity to process MR2 forms. We are confident that we will be able to process MR2s on an expedited basis in order to quickly qualify people for waiver eligibility. Effective immediately and until March 30, 2006, we will also waive some of the standardized requirements outlined in the CAP-MR/DD Manual. Murdoch will accept psychological evaluations for children that have been completed

within three years and for adults if they were completed within five years. They will also accept MR2s that have been signed within 60 days, rather than the standard 30 day requirement.

When the LME and case manager have been notified that a person has been determined to meet ICF/MR LOC, the case manager should prepare an abbreviated POC to seek approval, effective March 20, 2006, for just the service (or services) that will most closely replace CBS services currently being received by the consumer. The immediate goal up until March 20, 2006 is to assure that consumers will not be faced with a loss of service with the implementation of new Enhanced Services. After this critical emergency time period has passed, case managers should go back and work with the consumer and their family to develop the full Person Centered Plan, including natural and community supports, for approval for all medically necessary waiver services. Complete PCPs for all consumers added to the waiver through this effort must be completed July 20, 2006.

Community Support

For those individuals who have a developmental disability but do not meet ICF/MR level of care and who are receiving CBS services primarily for a co-occurring mental illness, substance use disorder, or behavioral issue, the most appropriate replacement service is Community Support. Case managers may quickly amend the treatment plan to replace Community Support in accordance with the crosswalk instructions outlined in our January 19, 2006 correspondence.

Medicaid Personal Care Service

Medicaid Personal Care Services (PCS) may meet many of the needs for individuals who do not meet ICF/MR LOC and who are receiving CBS primarily for issues related to their developmental disabilities. Attached to this memorandum please find an introductory "fact sheet" about Medicaid PCS and copies of the forms used to authorize PCS. Case managers should immediately refer individuals who appear to qualify for PCS to a home care or home health agency for an assessment to determine if PCS will meet some or all of their needs.

State Funded Developmental Therapy

If none of the previous options work or only work partially – the consumer does not qualify for the CAP-MR/DD Waiver, they do not need CBS due to a mental health/substance abuse/behavioral issue, they do not qualify to receive PCS or PCS will not fully meet their needs – case managers may authorize state funded Developmental Therapy services. The state funded Developmental Therapy service will follow the same service definition that was submitted to CMS for approval and will be paid at the rates developed for the proposed Medicaid service. DMH/DD/SAS will issue by February 10, 2006 the authorization guidelines to be followed in authorizing this new state service.

We realize that the efforts to quickly identify individual solutions for the nearly 5,000 individuals impacted by this federal decision will be a massive undertaking. We know that this plan places a large burden on case managers and LME local approvers. We hope that you agree with us that the people we serve who would otherwise lose services as a result of the federal government's decision deserve no less than our best efforts to ensure the success of this plan. We understand that there will be inevitable implementation glitches. If case management providers or LMEs have questions about this plan, please direct them to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services by e-mailing contactdmh@ncmail.net.

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMH/DD/SAS Staff
Rob Lamme
Rich Slipsky
Wayne Williams
Kaye Holder
Coalition 2001 Chair
Mark Benton
Dr. William Lawrence
Tara Larson
Carol Robertson
Angela Floyd

Appendix F. LME and LEA and Regional Contacts

Cross Reference of DPI-DMH-LME-LEA Representatives as of 11-Oct-05. Please update as needed. Contact information for regional staff is provided on the last page.

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
ALAMANCE	Mattie Muwwakkil	Alamance Caswell Rockingham	Lena Klumper	Lee Hall-Worthington	Felissa Ferrell
ALEXANDER	Beth Robinson	Foothills	Beth Whitaker	Sharon White	Jim Greer
ALLEGHANY	Beth Robinson	New River	Bill Bullington	Betsy Owen	Jim Greer
ANSON	Mattie Muwwakkil	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
ASHE	Beth Robinson	New River	Bill Bullington	Betsy Owen	Jim Greer
AVERY	Beth Robinson	New River	Bill Bullington	Betsy Owen	Jim Greer
BEAUFORT	Joan Bond	Tideland	Rose Burnette	Victor Armstrong; Kelly Ayscue, Community Collaboration	Barbara Thomas
BERTIE	Joe Simmons	Roanoke Chowan	Rose Burnette	Cham Trowell	Barbara Thomas
BLADEN	Joan Bond	Southeastern Regional	Mabel McGlothlen	Laura Smith Allen; Kathy Baker, Planning and Collaboration	Wes Rider
BRUNSWICK	Joan Bond	Southeastern Center	Marie Kelley	Tony Evans, Community Collaborative; Carolyn Craddock, Customer Services	Wes Rider
BUNCOMBE	Beth Robinson	Western Highlands	Marie Kelley	Vince Newton	Jim Greer
BURKE	Beth Robinson	Foothills	Beth Whitaker	Sharon White	Jim Greer

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
CABARRUS	Dana Rusher	Piedmont	Ken Marsh	Jill Lineberger, CPSS Director; Steve Tomlinson, Community Relations	Cathy Kocian
CALDWELL	Beth Robinson	Foothills	Beth Whitaker	Sharon White	Jim Greer
CAMDEN	Joe Simmons	Albemarle	Dick Oliver		Barbara Thomas
CARTERET	Joan Bond	Neuse	Ken Marsh	Mary Katherine Harris	Wes Rider
CASWELL	Mattie Muwwakkil	Alamance Caswell Rockingham	Lena Klumper	Lee Hall-Worthington	Felissa Ferrell
CATAWBA	Dana Rusher	Catawba	Beth Whitaker	Gail Henson	Cathy Kocian
CHATHAM	Mattie Muwwakkil	Orange-Person-Chatham (OPC)	Mabel McGlothlen	Lisa Lackmann	Michael Bramwell
CHEROKEE	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
CHOWAN	Joe Simmons	Albemarle	Dick Oliver	Cham Trowell	Barbara Thomas
CLAY	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
CLEVELAND	Dana Rusher	Pathways	Mabel McGlothlen	Dawn Wilson	Cathy Kocian
COLUMBUS	Joan Bond	Southeastern Regional	Mabel McGlothlen	Laura Smith allen; Kathy Baker, Planning and Collaboration	Wes Rider
CRAVEN	Joan Bond	Neuse	Ken Marsh	Mary Katherine Harris	Wes Rider

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
CUMBERLAND	Joe Simmons	Cumberland	Rayne Caudill	Debbie Jenkins, Child & Family Services & QA/QI; Vince Wagner, Provider Relations	Wes Rider
CURRITUCK	Joe Simmons	Albemarle	Dick Oliver		Barbara Thomas
DARE	Joe Simmons	Albemarle	Dick Oliver		Barbara Thomas
DAVIDSON	Mattie Muwwakkil	Piedmont	Ken Marsh	Jill Lineberger, CPSS Director; Steve Tomlinson, Community Relations	Cathy Kocian
DAVIE	Dana Rusher	Centerpoint	Mark O'Donnell		Felissa Ferrell
DUPLIN	Joan Bond	Eastpointe	Marie Kelley	Phyllis Greene, Community Collaborative; Becky Cale, Customer Services & Provider Relations; Thomasine Kennedy, Policy Development	Wes Rider
DURHAM	Mattie Muwwakkil	Durham	Lena Klumper	Robert Robinson	Felissa Ferrell
EDGECOMBE	Joe Simmons	Edgecombe Nash Wilson Greene	Marie Kelley	Dwight Harper, Children's service in schools & Community Collaborative	Barbara Thomas

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
FORSYTH	Dana Rusher	Centerpoint	Mark O'Donnell		Felissa Ferrell
FRANKLIN	Mattie Muwwakkil	Five County	Mark O'Donnell		Felissa Ferrell
GASTON	Dana Rusher	Pathways	Mabel McGlothlen	Dawn Wilson	Cathy Kocian
GATES	Joe Simmons	Roanoke Chowan	Rose Burnette	Cham Trowell	Barbara Thomas
GRAHAM	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
GRANVILLE	Mattie Muwwakkil	Five County	Mark O'Donnell		Felissa Ferrell
GREENE	Joe Simmons	Edgecombe Nash Wilson Greene	Marie Kelley	Amy Cox, Community Collaborative	Barbara Thomas
GUILFORD	Mattie Muwwakkil	Guilford	Mark O'Donnell	Paula Snipes, Community Capacity; Ed Eklund, Relationship with Schools	Felissa Ferrell
HALIFAX	Joe Simmons	Five County	Mark O'Donnell		Felissa Ferrell
HARNETT	Joe Simmons	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
HAYWOOD	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
HENDERSON	Beth Robinson	Western Highlands	Bill Bullington	Vince Newton	Jim Greer
HERTFORD	Joe Simmons	Roanoke Chowan	Rose Burnette	Cham Trowell	Barbara Thomas
HOKE	Joe Simmons	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
HYDE	Joan Bond	Tideland	Rose Burnette	Victor Armstrong; Kelly Ayscue, Community Collaboration	Barbara Thomas
IREDELL	Dana Rusher	Crossroads	Beth Whitaker	Tammie Wellman, Provider Relations; Candice Tilley	Felissa Ferrell

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
JACKSON	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
JOHNSTON	Joe Simmons	Johnston	Rayne Caudill	Alice O'Neal, Child Service Mgr.; Angela Hinnant Provider Relations	Barbara Thomas
JONES	Joan Bond	Neuse	Ken Marsh	Mary Katherine Harris	Wes Rider
LEE	Joe Simmons	Sandhills	Ken Marsh	Michael Martin, Child services	Michael Bramwell
LENOIR	Joan Bond	Eastpointe	Marie Kelley	Phyllis Greene, Community Collaborative; Becky Cale, Customer Services & Provider Relations; Thomasine Kennedy, Policy Development	Wes Rider
LINCOLN	Dana Rusher	Pathways	Mabel McGlothlen	Dawn Wilson	Cathy Kocian
MACON	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
MADISON	Beth Robinson	Western Highlands	Bill Bullington	Vince Newton	Jim Greer
MARTIN	Joan Bond	Tideland	Rose Burnette	Victor Armstrong; Kelly Ayscue, Community Collaboration	Barbara Thomas
MCDOWELL	Beth Robinson	Foothills	Beth Whitaker	Sharon White	Jim Greer

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
MECKLENBURG	Dana Rusher	Mecklenburg	Mark O'Donnell	William Sims, Provider Coordinator; Dana Humphries, Education Liaison	Cathy Kocian
MITCHELL	Beth Robinson	Western Highlands	Bill Bullington	Vince Newton	Jim Greer
MONTGOMERY	Mattie Muwwakkil	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
MOORE	Mattie Muwwakkil	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
NASH	Joe Simmons	Edgecombe Nash Wilson Greene	Marie Kelley	Dwight Harper, Children's service in schools & Community Collaborative	Barbara Thomas
NEW HANOVER	Joan Bond	Southeastern Center	Marie Kelley	Judith Wall, School contact	Wes Rider
NORTHAMPTON	Joe Simmons	Roanoke Chowan	Rose Burnette	Cham Trowell	Barbara Thomas
ONSLOW	Joan Bond	Onslow	Rayne Caudill	Jessica Charters, QM	Wes Rider
ORANGE	Mattie Muwwakkil	Orange-Person-Chatham (OPC)	Mabel McGlothlen	Lisa Lackmann	Michael Bramwell
PAMLICO	Joan Bond	Neuse	Ken Marsh	Mary Katherine Harris	Wes Rider
PASQUOTANK	Joe Simmons	Albemarle	Dick Oliver		Barbara Thomas
PENDER	Joan Bond	Southeastern Center	Marie Kelley	Tony Evans, Community Collaborative; Carolyn Craddock, Customer Services	Wes Rider

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
PERQUIMANS	Joe Simmons	Albemarle	Dick Oliver		Barbara Thomas
PERSON	Mattie Muwwakkil	Orange-Person-Chatham (OPC)	Mabel McGlothlen	Lisa Lackmann	Michael Bramwell
PITT	Joan Bond	Pitt	Rose Burnette	Nancy Cleghorn, Care Mgmt.	Barbara Thomas
POLK	Beth Robinson	Western Highlands	Bill Bullington	Karen Lawing	Jim Greer
RANDOLPH	Mattie Muwwakkil	Sandhills	Ken Marsh	Lucy Dorsey	Michael Bramwell
RICHMOND	Mattie Muwwakkil	Sandhills	Ken Marsh	Mark Marquez	Michael Bramwell
ROBESON	Joan Bond	Southeastern Regional	Mabel McGlothlen	Laura Smith allen; Kathy Baker, Planning and Collaboration	Wes Rider
ROCKINGHAM	Mattie Muwwakkil	Alamance-Caswell-Rockingham	Lena Klumper	Teresa Price	Felissa Ferrell
ROWAN	Dana Rusher	Piedmont	Ken Marsh	Jill Lineberger, CPSS Director; Steve Tomlinson, Community Relations	Cathy Kocian
RUTHERFORD	Beth Robinson	Western Highlands	Bill Bullington	Karen Lawing	Jim Greer

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
SAMPSON	Joan Bond	Eastpointe	Marie Kelley	Phyllis Greene, Community Collaborative; Becky Cale, Customer Services & Provider Relations; Thomasine Kennedy, Policy Development	Wes Rider
SCOTLAND	Joan Bond	Southeastern Regional	Mabel McGlothlen	Laura Smith allen; Kathy Baker, Planning and Collaboration	Wes Rider
STANLY	Dana Rusher	Piedmont	Ken Marsh	Jill Lineberger, CPSS Director; Steve Tomlinson, Community Relations	Cathy Kocian
STOKES	Dana Rusher	Centerpoint	Mark O'Donnell		Felissa Ferrell
SURRY	Dana Rusher	Crossroads	Beth Whitaker	Tammie Wellman, Provider Relations; Candice Tilley	Felissa Ferrell
SWAIN	Beth Robinson	Smoky Mountain	Bill Bullington	Denise Gaskin	Jim Greer
TRANSYLVANIA	Beth Robinson	Western Highlands	Bill Bullington	Vince Newton	Jim Greer
TYRRELL	Joan Bond	Tideland	Rose Burnette	Victor Armstrong; Kelly Ayscue, Community Collaboration	Barbara Thomas

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
UNION	Dana Rusher	Piedmont	Ken Marsh	Jill Lineberger, CPSS Director; Steve Tomlinson, Community Relations	Cathy Kocian
VANCE	Mattie Muwwakkil	Five County	Mark O'Donnell		Felissa Ferrell
WAKE	Joe Simmons	Wake	Rayne Caudill	Beth Nelson, child services; Greta Gill, Community Development; Jeff Hildreth, DD Services; Pam Wheeler, School Based MH Team	Michael Bramwell
WARREN	Mattie Muwwakkil	Five County	Mark O'Donnell		Felissa Ferrell
WASHINGTON	Joan Bond	Tideland	Rose Burnette	Victor Armstrong; Kelly Ayscue, Community Collaboration	Barbara Thomas
WATAUGA	Beth Robinson	New River	Bill Bullington	Betsy Owen	Jim Greer
WAYNE	Joan Bond	Eastpointe	Marie Kelley	Phyllis Greene, Community Collaborative; Becky Cale, Customer Services & Provider Relations; Thomasine Kennedy, Policy Development	Wes Rider

County/LEA	DPI Exceptional Children Regional Consultant	LME	LME Liaison DMH/DD/SAS	LME Point Person	Regional Advocacy Specialist DMH/DD/SAS
WILKES	Beth Robinson	New River	Bill Bullington	Betsy Owen	Jim Greer
WILSON	Joe Simmons	Edgecombe-Nash-Wilson-Greene	Marie Kelley	Amy Cox, Community Collaborative	Barbara Thomas
YADKIN	Dana Rusher	Crossroads	Beth Whitaker	Tammie Wellman, Provider Relations; Candice Tilley	Felissa Ferrell
YANCEY	Beth Robinson	Western Highlands	Bill Bullington	Vince Newton	Jim Greer

State Level Resources

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Appendix G. Interventions for Children with Behavioral-Emotional Disabilities through the School System

Screening for Behavioral-Emotional Disabilities

General education teachers should be sensitized to the characteristics which may indicate behavioral-emotional disabilities, ranges of normal behavior relative to respective developmental levels of students, as well as the extreme nature and potential ramifications of a student acquiring the label of behavioral-emotional disabled. Efforts to provide such an awareness and information through in-service training or other methods should diminish the potential for premature or unnecessary concerns.

The Referral

When a teacher, parent or other involved person recognizes that a student is exhibiting developmental problems or that a child's educational needs are not being met, he/she will provide in writing the reason for the referral, addressing the specific presenting problems and the child's current strengths and weaknesses or needs. This referral shall be given to the principal of the school, the child's teacher or other school professional, or the superintendent or other appointed official of the local educational agency.

The referral shall be given to the Individual Education Program (IEP) Team no later than ten school days from the time it is received by one of the above named persons. The IEP Team will review the referral, determine if the referral is appropriate, and obtain parental consent for evaluation. If the IEP Team determines the referral is not appropriate, it will notify the parents of that fact and provide them with a copy of the referral stating the reasons in writing why it did not proceed with the evaluation and provide them with a copy of their procedural safeguards, informing them of their right to a due process petition for failure to evaluate.

Focus of Concern

If the IEP Team determines that the referral is appropriate because the student is experiencing significant difficulties indicative of a behavioral or learning problem, the next step is to complete a **Focus of Concern/ Screening**. The recommended state form for this purpose is the **RE1/HCA** (See Appendices). This document describes problem situations, efforts to solve the problem through behavioral and/or classroom management strategies, and the resulting impact of these efforts to modify the student's identified problem. The form also documents the name of the student and the teacher presenting acknowledgment of the concern. It is used for each of the steps in the pre-referral and screening process.

Parental Notification

The next step entails the notification of the parent or guardian that the school will be generating and gathering information to assist the student in optimizing benefits from his/her current general education program. The recommended state form for this is the **RE 2**. Since the parent or

guardian is a member of the IEP Team, this notification may come as part of the decision for an evaluation.

Screening

The goal of the screening process is to identify students experiencing behavioral and/or learning problems and provide early intervention and supportive assistance within the general education program. This process of identification should be accomplished by systematic screenings at regular intervals to identify specific academic, behavioral, or developmental needs through school-wide achievement, health and sensory testing. Individual screenings may be warranted for specific problems which might require further consideration of follow-up evaluations or consideration for referral for special education services.

Specific required screening procedures for students exhibiting behavioral/emotional problems include:

1. Documented efforts to **confer with parents/guardians** for the purpose of discussing solutions to the student's specific problems and notification of the screening process;

2. **Systematic observation** of the student in the classroom by a third party who records incidents and describes the nature of the behavior leading to the referral;

3. **Review of the records** to determine information on attendance, history of academic or behavioral problems, medical information, past referrals, anecdotal comments, samples of work or any information relevant to social functioning, and environmental and cultural status;

4. Vision screening;

5. Hearing screening; and

6. Documented evidence of at least **two appropriate interventions** used in the classroom to make behavioral and academic achievements possible in the regular education setting, and the effect of each intervention on the student's behavior (see Section 1.2).

The information acquired through the screening process is not generated to diagnose or determine eligibility, but rather to assist in the design of interventions or modifications to remediate the focus of concern in the general education program. Frequently these classroom adjustments will result in more positive and responsible behavior by students.

Pre-referral Interventions and Supported Educational Assistance

The Safe Schools Act of 1997

Under Article 27A, “Management and Placement of Chronically Disruptive Students” in The Safe Schools Act of 1997, the principal of each school is to designate a committee that includes instructional personnel elected by the teachers, instructional support personnel, and administrators, to assist teachers with the management and placement of chronically disruptive students. According to the law “If, after a teacher has requested assistance from the principal two

or more times due to a student's chronically disruptive behavior, the teacher finds that the student's chronically disruptive behavior continues to interfere with the academic achievement of that student or other students in the class, the teacher may refer the matter to the committee. The committee shall review the matter and shall take one or more of the following actions: (i) advise the teacher on managing the student's behavior more effectively, (ii) recommend to the principal the transfer of the student to another class within the school, (iii) recommend to the principal a multidisciplinary diagnosis and evaluation of the student, (iv) recommend to the principal that the student be assigned to an alternative learning program, or (v) recommend to the principal that the student receive any additional services that the school or the school units has the resources to provide for the student."

This school wide committee might be the group that first identifies pre-referral interventions and/or preventive interventions for a student. Once a student has been referred to this committee for chronically disruptive behavior, the provisions of Child Find which determine whether a child has a disability and needs special education should be considered. If disciplinary action is necessary, the student may be considered to have the procedural safeguards of an identified exceptional student due to being referred to the committee.

The Assistance Team

Special Education teachers and regular education teachers have valuable skills and knowledge to assist students experiencing educational difficulties. Working together they can and should be able to resolve many learning and behavioral problems without an exceptional student's referral. Some school systems use the Assistance Team Model to facilitate this process.

The Assistance Team, using the screening data, can develop an intervention plan for the general education classroom. The team serves by:

- Assisting teachers in identifying and establishing interventions for students having educational difficulties;

- Providing an efficient, flexible, and cost effective problem-solving alternative prior to an exceptional student's program referral; and

- Providing support to teachers serving students with disabilities within the general education classroom.

The members of the Assistance Team should be dependent upon the nature of the presenting problem and the staffing pattern of the building. The team should be viewed as a problem-solving mechanism. For this reason, the number of members should be kept to a minimum. Many schools keep the membership to four or five in number. Members of the Assistance Team could include:

- Instructional staff familiar with the student's needs;

- In elementary school it may be appropriate for the team to include a teacher of the student's grade level. If the student is in middle school and the teachers are departmentalized into a team, then teachers of the student's department or team should be on the assistance team. In high school if the problem is in a specific academic area (for example, math) then a teacher from that

area may be appropriate. Teachers from the student's current classes would be appropriate for this team, particularly if the problem is general and not related to a specific area.

- Chapter I teacher or other remedial program teacher;
- Counselor;
- Special educators (ex. resource teachers, speech-language pathologist);
- School psychologist;
- Social worker; and
- School administrator.

Pre-referral Interventions

The screening data should be used to develop the interventions for the general education classroom. The following suggested variables may warrant examination and/or modification:

Instructional methodology
- modification of classroom materials or selection of alternative materials
- use of a specific remedial program
- reduction in the amount of work given
- reduction of the complexity of the content or directions
- a task analysis analyzing student problem areas
- use of specialized instructional equipment
- use of Chapter I or other supports

Classroom organizational factors
- use of an aide, volunteer or peer tutor
- use of preferential seating
- change in the student's class schedule
- change in the student's teacher

Classroom management system
- use of specific behavior management strategies, such as a point system
- motivation of students through positive verbal and concrete reinforcement strategies (use of praise and attention)
- identification and use of appropriate individual student reinforcers
- development of clearly defined expectations that are consistent
- definition of behaviors in positive terms
- use of intervention strategies before problems escalate
- plan for a defined continuum of positive and negative consequences that will be used consistently
- development of a teacher and student designed plan of intervention to use during "crisis" times
- development of a student behavioral contract
- use of time-out

Direct instruction of skill deficits necessary for responsible behavior
- identification of behaviors in direct observable terms
- provision of opportunities for specific feedback and correction or reteaching of desired skill
- provision of opportunities for independent student practice of desired behavior
- review of daily progress with the student
- instruction in use of self-monitoring techniques for targeted behaviors
- use of behavior chart
- provision of individual counseling or social skills groups

Consultation with parents
- initiation of student conferences to ensure accurate targeting of behaviors
- use of at-home reinforcers and contingencies for behavior
- implementation of a home-school checklist
- use of counseling and/or support groups

The Assistance Team will meet after the plan is implemented [from three (3) to six (6) weeks] to discuss the student's progress and possible adjustments to the plan. When the recommended strategies have proved effective, a period of continued monitoring may be established prior to the exit of the Assistance Team function. When the recommended strategies have not proven effective in solving identified problems, the Assistance Team has several options:
- repeating the strategies,
- trying additional strategies, or
- entering the referral process (all data collected by the assistance team should accompany the referral).

Referral

After reviewing screening data and the effects of recommended strategies, the team may determine that a referral for evaluation is necessary if all of the following conditions apply:

- specific interventions implemented were not effective,
- vision and hearing and mental ability appear to be within normal limits, and
- it is determined that the documented maladaptive behavior appears to be long standing or of such frequency or intensity as to interfere with the student's own learning process.

The recommended state form for this referral is the **Exceptional Students Referral**, **DEC 1**. Before an evaluation can begin, **Prior Notice and Consent for Evaluation**, **DEC 2** and a **Handbook on Parent's Rights** must be sent to the parent or guardian in order to obtain consent for the evaluation.

90 days is allotted from the time the referral is made until the placement decision is approved by the IEP Team.

Multidisciplinary Diagnostic Evaluation

When the decision is made to refer the student, the assessment occurs. The recommended state form used to summarize evaluation results is the **Summary of Evaluation Results**, **DEC 3**. The required evaluation of students with behavioral-emotional disabilities includes the following areas:

Behavioral-Emotional Evaluation

The evaluation of behavioral-emotional functioning shall be conducted by a certified or licensed psychologist to document maladaptive behaviors or deficits in coping skills and emotional functioning. A behavioral-emotional evaluation includes the information about the unique personal attributes of the student and describes any distinctive patterns of behavior which characterize the student's personal feelings, attitudes, moods, perceptions, thought processes, and significant personality traits. The evaluation shall include:

- interviews with the student,
- checklists or rating scales, and
- screening data and any other observational data.

Educational Evaluation

A comprehensive educational evaluation conducted by a certified psychologist, special educator, or other trained professional shall include an assessment of :

- the learning environment, including curriculum and task demands;
- academic strengths and weaknesses, including written and oral language and information from individualized achievement assessment;
- present levels of academic functioning; and
- vocational needs (for students age 14 and older).

Psychological Evaluation

A psychological evaluation shall be conducted by a certified or licensed psychologist. This evaluation includes interviews with the student, learning history, and behavioral observations with special consideration given to evaluation of disorders of thought, memory, judgment, and /or time-place orientation as appropriate. An individual intellectual evaluation shall be given when academic or learning deficits or giftedness is suspected.

Social /Developmental History

A social/developmental history documents normal and abnormal developmental events and includes a review of information developed during the screening process. The history may be obtained by a certified social worker, special educator, psychologist, counselor or other appropriate person.

Other recommended evaluations which may be warranted include:

A. a medical evaluation, and
B. a speech-language evaluation.

Individualized Education Program Team

The Individualized Education Program Team (IEP Team) is responsible for making decisions about initial evaluations (if appropriate) and reevaluations; the individualized education program (IEP); placement, including alternative education setting; and discipline, including the relationship between the disability and behavior when the behavior will result in a suspension of more than ten days in a school year.
At least one member of the IEP Team should be the same sex and same race as the student being referred.

Members of the IEP Team must include:

- a representative of the local education agency who
- is qualified to provide, or supervise the provision of specially designed instruction to meet the unique needs of children with disabilities,
- is knowledgeable about the general curriculum,
- is knowledgeable about the availability of resources of the local educational agency;
- at least one special education teacher of that child;
- at least one regular education teacher of the child (if the child is, or may be participating in the regular education environment);
- an individual who can interpret the instructional implications of evaluation results, who may be a member of the team described above;
- the parents of the child;
- at the discretion of the parent or the local education agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate;
- the child when transition services are discussed and whenever else appropriate;
- when discussion of transition services will occur, a representative of any other agency that is likely to be responsible for providing or paying for transition services.

Definition and Criteria for Eligibility Determination

In North Carolina, students who are disabled by emotional and behavioral problems are classified as behaviorally-emotionally disabled. The term behaviorally-emotionally disabled (BED) is synonymous with serious emotional disturbance (SED) which is defined as follows in the Individuals with Disabilities Education Act:

Serious Emotional Disturbance
Federal Definition
CFR 300.7 (a) (i)

The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance-

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors;
(B) An inability to build or maintain satisfactory relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes schizophrenia. The term does not apply to students who are socially maladjusted, unless it is determined that they have an emotional disturbance.

This definition, with the exception of the exclusionary clause for social maladjustment, began with the work of Eli Bower in the 1950's. Initially, in July of 1972, it appeared essentially in its present form as an implementing regulation of Public Law 91-230. With the passage of Public Law 94-142 in 1975, serious emotional disturbance was established as a special education category within that law. Since this adoption, the undefined exclusion (of socially maladjusted students) and ambiguous language have presented an enigma for school personnel. These ambiguities have led to alternative interpretations and disparate treatment of students and youth across jurisdictions (Cline, 1990). In a position paper on the definition, the Council for Students with Behavioral Disorders posits that students with emotional disturbances are underserved primarily due to poorly defined and restrictive federal eligibility criteria (1987).

The purpose of this portion of the manual is to provide technical assistance to IEP teams in making eligibility determinations for special education services for students under consideration for classification as behaviorally-emotionally disabled.

Behaviorally-Emotionally Disabled
State Definition

.1501 A. (2) Procedures Governing Programs and Services for Students with Special Needs

School-aged students who, after receiving specially designed support services and intervention strategies in the regular education setting, still exhibit patterns of situationally inappropriate interpersonal or intrapersonal behavior. The inappropriate behaviors must be long standing patterns of behavior which occur regularly and often enough as to interfere consistently with the student's own learning process. A behavioral-emotional disability is evidenced by one or more of the following characteristics which cannot be attributed primarily to physical, sensory, or intellectual deficits:

(a) inability to achieve adequate academic progress (not due to a learning disability);
(b) inability to maintain satisfactory interpersonal relationships;
(c) inappropriate or immature types of behavior or feelings under normal conditions;
(d) a general mood of unhappiness or depression;
(e) a tendency to develop physical symptoms, pains, or fears associated with personal or school problems.

The term does not include the socially maladjusted student unless it is determined that he/she is also behaviorally-emotionally disabled.

NOTE: Not applicable for preschool students.

Special Education Eligibility Determinations

Eligibility criteria for all categories of disabilities defined in state and federal law contain language which either specifically states or implies that conditions exist which "**adversely affect educational performance**." It is critical that professionals who make decisions about the eligibility of students with potential behavioral-emotional disabilities be competent to make those decisions based on clear distinctions among educational performance, academic progress, and social competence.

Educational performance is a comprehensive term which includes both academic progress and social competence. It reflects the total involvement of the student in the school environment. In addition to academic progress and social competence, it includes access to and participation in school activities, emotional development, and communication skills. Social skills and adaptive behaviors which enable students to meet environmental demands and assume responsibility for his/her and others' welfare are elements of social competence which is one aspect of educational performance. Since social development is a necessary and critical component of a student's educational performance, deficits in social competence which impair one's ability to form and maintain interpersonal relationships with adults and peers may qualify the student for behaviorally-emotionally handicapped services regardless of academic achievement if other identifying criteria are met.

Academic progress is less comprehensive than educational performance and refers to a student's progress in core academic subjects as measured by achievement tests, report cards, work samples, curriculum-based assessments, etc. Standardized and informal measures of academic performance are critical tools in evaluating student progress in the core academic subjects but are not adequate measures of educational performance.

Social competence is the area which encompasses a student's specific behavioral repertoire of adaptive and maladaptive behavior, adaptive functioning skills, and social skills development. Assessment of a respective student's social competence may include measures of adaptive functioning, social skills, and specific target behaviors as well as interviews and behavioral observations. Other psychometric constructs such as behavioral ratings, sociometrics, self-reports, and projectives may also be utilized.

As specified in the definitions of **serious emotional disturbance (SED)** in the **Individuals with Disabilities Education Act (*IDEA*)**, and **behavioral-emotional disabled (BED)** in *North Carolina's Procedures Governing Programs and Services for Students with Special Needs*, students must exhibit at least one of the five commonly accepted identifying characteristics. These one or more characteristics must be present along with all four of the qualifying criteria. The following descriptors provide some clarification of the somewhat ambiguous language used in the definition in order to assist the multi-disciplinary evaluation teams in making eligibility determinations:

Identifying Characteristics

1. "An inability to learn which can not be explained by intellectual, sensory, or health factors"

The "inability to learn" is somewhat troubling or misleading to educators who know that all students can and do learn. A more practical interpretation allows for degrees of inability to learn. The primary issue is to determine if a significance exists between a student's learning potential and his/her actual learning. It is, therefore, possible for a student of superior intellectual aptitude, who is achieving commensurate with grade expectations but below his/her potential, to be identified as behaviorally-emotionally disabled.

Once a determination has been made that a discrepancy exists between the aptitude to learn and the actual learning, the evaluation team must determine that this condition "can not be explained by intellectual, sensory, or health factors." Some degree of contribution from one of these factors may be present, but it must be determined that such factor(s) are not the primary problem. (e.g. Students who have been identified behavioral-emotional disabled may have a specific learning disability or a developmental disability. However, it must be determined that such disabilities are

not the primary cause of the learning problem.) The eligibility determination should indicate that the severity of the behavioral-emotional disability is such that the student would not be more appropriately served in another general or special education program.

2. "An inability to build and maintain satisfactory interpersonal relationships with peers and teachers"

For a student to qualify for special education under this characteristic, sufficient evidence from multiple sources should support that the student's deficits in social competence impair his/her ability to build and maintain satisfactory interpersonal relationships with others. This characteristic must be present at an unacceptable level across various environments. Students do not qualify for special education because they have problems with a particular teacher, peer, or group.

This characteristic may not be considered present in students who have appropriate satisfactory relationships with peers in their subcultures yet function adversely to broader community norms. Behavioral characteristics manifested by students with behavioral-emotional disabilities which impair their ability to build and maintain satisfactory relationships include but are not limited to extreme social withdrawal, poor reality testing, social or interpersonal deficits, aggressive and authority challenging behaviors, and oppositional tendencies.

3. "Inappropriate types of behaviors or feelings under normal circumstances"

To meet the criteria for this identifying characteristic, student behavior must be inappropriate under normal circumstances and across time. Behaviors may include, but not be limited to, overreaction to environmental stimuli, obsessive or compulsive behaviors, bizarre verbalizations, inappropriate sexualized behaviors or fetishes.

Feelings, by definition, are not objectively observable or measurable. It is quite difficult to ascertain the feelings of others except through inferences drawn from observable behaviors and interactions with the student. When making eligibility determinations based on feelings alone, there should ostensibly be a strong consensus among multidisciplinary evaluation team members that there exists documented evidence of persistent and significantly inappropriate feelings demonstrated by observed behavior that are not appropriate for the context in which they are manifested. Clinical interviews, objective and projective psychological tests, and other measures can be useful as assessment information to support behavioral observations indicative of this identifying characteristic.

4. "A general mood of unhappiness or depression"

Depression or other affective conditions may best be recognized when the behavior of the student is such that one would consider the student to have a pervasive mood of unhappiness or depression. This condition may be observed by the commonly accepted characteristics of withdrawal from friends, frequent crying, markedly diminished interest in activities, depressive affect, and anxiety, or it may be masked by angry, aggressive, or agitated behaviors.

Suicidal and homicidal ideations, obsessions with morbid themes, and sleep disturbances are also common characteristics of depression. If such prevalent, disturbed moods and thoughts are situationally specific, they do not constitute a general mood of unhappiness or depression unless they become a protracted state. Consideration should obviously be given to alternative or additional solutions or services such as school counseling or mental health services to assist the student in the treatment of mood disorders.

5. "A tendency to develop physical symptoms or fears associated with personal or school problems"

It is quite common for students to react to stress or tension with physical symptoms at one time or another. This identifying characteristic must occur "to a marked degree" and "over a long period of time." Therefore this condition must be chronic and not an acute reaction to a particularly stressful event. These symptoms must, therefore, be debilitating to the extent that they provide a significant interference with learning.

There is a myriad of physical responses in students which may be caused by emotional distress. These reactions can/may be considered as long as there is reasonable evidence that such physical manifestations have a psychosomatic origin. Efforts to mitigate the symptoms of these fears or phobias such as systematic desensitization, relaxation techniques, and medication are appropriate prior to consideration of a referral for special education.

The Four Qualifiers

1. "Long-standing patterns of behavior"

The determination of what establishes long-standing patterns of behavior is subject to the professional judgment of the multi-disciplinary team. To establish long-standing patterns, the referred student must exhibit one or more of the five characteristics of behavioral-emotional disabilities in such duration as to be considered chronic. Chronicity is determined by behavioral manifestations which establish sustained patterns, high frequency occurrences over shorter periods, or multiple acute incidences. The behavioral history of the student should indicate that the behavioral pattern is not a response to a situational crisis or a reaction to a transitory situation. This qualifier is intended to exclude behavioral and emotional disturbances which would be expected to subside over time under normal circumstances. The occurrence of single events or severe isolated incidents does not necessarily qualify a student for special education under the category of behaviorally-emotionally disabled. The developmental level of the referred student should be given consideration when making determinations regarding what constitutes long standing patterns. Sources of information which are helpful in making these determinations are developmental history, social history, school history, or other anecdotal information regarding the student's behavior in the school, home, or community.

2. "After receiving specially designed support services and intervention strategies in the regular education setting"

Students who present behavioral-emotional difficulties in the general education program can not qualify for special education services as behavioral-emotional disabled unless specific interventions have been implemented with respect to the presenting problems, and the student continues to manifest behaviors consistent with the definition. This supportive educational assistance should be provided for a sufficient period of time (e.g. 6-8 weeks) to modify the targeted behavior and should be evaluated to determine its effectiveness. The purpose of this qualifier is to emphasize the school system's responsibility for utilizing existing resources and strategies in the general education setting prior to initiating a special education referral. Assistance teams are recommended to provide preventative and problem-solving assistance to classroom teachers for students in the general education program who are experiencing behavioral and learning difficulties. These services may include modifications in curricula, instructional methodology or behavior management which have previously proven effective for other students with similar

difficulties. Consideration may also be given to referring the student for services rendered from local community human service agencies that may assist the student and his/her family in addressing the behavioral or learning difficulty.

3. "Behavior of such frequency, intensity, and duration"

This qualifier in the North Carolina definition for behaviorally-emotionally disabled is similar to the "marked degree" terminology used in the federal definition of seriously emotionally disturbed. The dysfunctional behaviors which characterize students with behavioral and emotional disabilities are to a lesser degree evidenced by many students in the general education program from time to time. To qualify for special education these behaviors must be exhibited at a far greater rate and/or intensity than evidenced by a typical peer group. This significant difference should be observable and be manifested in multiple environments rather than specific to one particular situation or classroom.

In determining a marked degree, attention should be given to the following characteristics of a specific problem behavior:

frequency - the number of occurrences of a given behavior over a given period of time,
duration - the average amount of time that the student engages in a given behavioral occurrence, and
intensity - the relative strength, disruptiveness or intrusiveness of a given behavioral occurrence.

4. "Across settings"

Eligibility for special education should rely on a number of different sources and kinds of information. Assessment of a student's problematic behavior should occur across a variety of settings which constitute the comprehensive educational environment of the student. Consideration should be given to a variety of instructional groupings, including non-academic and extra-curricula groups. The student's community-based activities, as well as social behavior at home, should also be considered.

Social Maladjustment

The social maladjustment exclusionary clause in the federal definition of serious emotional disturbance has caused considerable confusion and controversy for those educators assigned the responsibility of making eligibility determinations for special education services. The merits and problems associated with the exclusion have been widely debated (Bower, 1982; Clarizio, 1987; CCBD, 1987, 1990; Kauffman, 1980; Long, 1983; Neel & Rutherford, 1981; Nelson & Rutherford, 1990; Peterson, Benson, Edwards, White & Rosell, 1986; Skiba & Jackson, 1989). Neither Public Law 101-476 nor its implementing regulations define the term "social maladjustment." Consequently this has led to considerable disagreement concerning the Congressional intent in formulating the exclusionary clause. (Bower, 1982; Center, 1989,1990; Clarizio, 1987; Raiser & Van Nagel, 1980; Slenkovich, 1983; Wood, Cheng, Cline, Smith & Geutzloe, 1989).

With the absence of federal guidelines, some professionals (DeYoung, 1984; Kester, 1983; Slenkovich, 1983) have advocated the utilization of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association classification system for identifying social maladjustments. This system equates internalized emotional problems with serious emotional disturbance, and externalized behavior or conduct problems with social maladjustment. Inherent in

this approach is the limited reliability of the diagnostic judgements based on symptomatology for which this system is based. Several studies have indicated that the interrater reliability of the DSM ranges from .50 to .55 (Achenbach, 1985; APA, 1980; Tharinger et al., 1986; Werry, Methven, Fritzpatrick & Dixon, 1983).

Other professionals have advocated for the use of behavioral checklists or rating scales to differentiate social maladjustments from serious emotional disturbances. This approach stems from the premise that the presence of two dichotomous dimensions of behavioral disorders--internalizing and externalizing--is an adequate basis for making the distinction between serious emotional disturbance and social maladjustment. However, this postulates that conduct problems and emotional disturbances are distinct and separate categories, an approach which does not appear to be supported by historical, legal, or empirical sources.

Contrary to attempts by many to provide restrictive interpretations, the federal definition, with its wide range of defining characteristics of the group eligible for services as seriously emotionally disturbed, has served to assure heterogeneity. Practitioners in the field are aware that the vast majority of students referred and served by special education as seriously emotionally disturbed exhibit problems conceptualized as externalizing, acting out, or conduct related. They are also aware that student's conduct disorders and emotional disturbances do not fit neatly into mutually exclusive categories. Therefore efforts to apply strictly defined boundaries in the diagnostic process are questionable given the realities of human behavior.

Differential diagnosis for social maladjustment has been plagued by a multitude of measurement problems. Extensive review of the methodology for distinguishing serious emotional disturbance and social maladjustment indicates that there is no assessment device or methodology which is both technically adequate and validated specifically for the purpose of distinguishing social maladjustment (Skiba & Grizzle, 1991). However, Public Law 101-476 specifically requires that measures used for educational evaluations be "validated for the specific purpose for which they are used." [C.F.R. 300.532 (a)(2)]

Despite the fact that empirical support for operationalizing the socially maladjustment exclusion does not appear to exist, the federal definition and a clear majority of state regulations include the clause in their procedures (Wright et. al., 1990). The clause appears to exclude students from being labeled as handicapped if they present delinquent behavior which they are fully capable of controlling and for which they are provided social support.

If the practitioner in the field suspects a child has behavioral or emotional difficulties and is in need of special education services, the evaluation team must conduct a comprehensive multi-faceted evaluation that addresses all areas of the eligibility criteria in the definition. The results of such evaluation should be the primary consideration for eligibility determination. For educational purposes, medical and/or psychiatric diagnoses do not, in and of themselves, qualify a child as seriously emotionally disturbed. This eligibility determination can only be made by a properly constituted multi-disciplinary team of persons knowledgeable about the student. If, after reviewing the results of an appropriate evaluation, the multidisciplinary team is satisfied that the student meets the criteria for seriously emotionally disturbed, it is inconsequential whether the student may also be socially maladjusted. Under the federal and state definitions, if the child meets one or more of the five identifying characteristics and the four qualifiers, he or she is eligible for special education services regardless of the presence or lack of social maladjustment.

Appendix H. Sample Local Solutions

On the following pages are samples submitted by various LEAs and LMEs as successful solutions to collaboration required by this transition. They include the following.

- Request for Proposal with Cleveland County Schools.
- Memorandum Of Understanding - Provision Of CBS Services In Cleveland County Schools
- Memorandum of Understanding between Wake County Human Services and Wake County Public School System
- Protocol and Criteria for Accessing CBS Services in the School Setting for Children
- Memorandum of Agreement between Agencies in Person County to Develop a Coordinated System of Care for Children with Serious Emotional Disturbance and Their Families

REQUEST FOR PROPOSAL WITH CLEVELAND COUNTY SCHOOLS

FOR SCHOOL SITED ONE-ON-ONE COMMUNITY BASED SERVICES (CBS) FOR CHILDREN AND FAMILIES

Questions regarding this RFP should be directed (via email only) to Bill McCullough, billmc@clevelandcountyschools.org (email address)

Final day for questions is June 22, 2005

Questions and Answers Session: June 16, 2005, 3:00 – 5:00 P.M.
Shelby High School Malcolm Brown Auditorium, AV Room
230 East Dixon Boulevard
Shelby, NC 28152

Applications (an original and 11 copies – 12 total)
Due: June 30, 2005 by 5:00 P.M.
To Bill McCullough
Cleveland County Schools
315 Patton Drive
Shelby, NC 28150

Services to begin at school sites on August 25, 2005

Cleveland County Schools

2005

RFP COVER SHEET FOR CLEVELAND COUNTY

Provider Organization:_____

Contact Person:_____

Phone:_____

Email Address:_____

Please check all feeder areas for which you are applying to provide services:

_____Burns
_____Crest
_____Kings Mountain
_____Shelby

Request for Proposal for the listed services to Authorized Consumers of Cleveland County
Proposals Due: June 30, 2005, 5:00 P.M.

INTRODUCTION
Cleveland County Schools ("CCS") is currently requesting proposals for school sited one-on-one Community Based Services for children and families for authorized consumers.

Through the proposal process, CCS intends to enter into a limited number of agreements with provider organizations whose services and qualifications are most responsive to the requirements of the attached application package, based on the service demand for the particular service. Agreements will be contingent upon approval by Cleveland County Schools and may be renewed and/or renegotiated at the end of the fiscal year, upon mutual consent of both parties. In selecting providers, CCS does not guarantee to providers a minimum number of referrals. In addition, CCS intends to periodically review school needs and adjust agreements with providers as needed.

Agreements with provider organizations will be designated for each of the four feeder areas in CCS: Burns, Crest, Kings Mountain, and Shelby. Provider organizations may apply to offer CBS services in any number of these feeder areas (1up to 4). The number of providers selected for each feeder area will be determined by the size of the student population in the feeder area and the capacity of the selected provider organization.

Feeder area information:
Burns Area - student population is approximately 4100
Schools include: Casar Elementary, Fallston Elementary, Union Elementary, Washington Elementary, Burns Middle, and Burns High.
Crest Area - student population is approximately 4700
Schools include: Boiling Springs Elementary, Springmore Elementary, Township Three Elementary, Crest Middle, and Crest High.
Kings Mountain Area - student population is approximately 4450
Schools include: Bethware Elementary, East Elementary, Grover Elementary, North Elementary, West Elementary, Kings Mountain Intermediate, Kings Mountain Middle, Kings Mountain High.
Shelby Area - student population is approximately 3600
Schools include: Elizabeth Elementary, Graham Elementary, James Love Elementary, Jefferson Elementary, Marion Intermediate, Shelby Middle, Shelby High.

INSTRUCTIONS FOR SUBMISSION OF PROPOSALS
Requirements
Responses to the RFP must be according to the format, content and sequence set forth in the body of the RFP. An authorized representative of the offeror must sign the proposal. Any proposal will be rejected if it is conditional, incomplete, or deviates from specifications set forth in this RFP. However, CCS reserves the right to accept any part of the proposal and not be obligated in any way to accept those parts that do not meet with the approval of CCS.

Completion of the RFP process does not bind CCS in awarding an agreement or to pay any associated costs for preparing a proposal. CCS, in its sole discretion, reserves the right to cancel this RFP in whole or in part.

All offerors are invited and encouraged to attend a pre-proposal question and answer session as indicated below:

Question and Answer Session:
June 16, 2005, 3:00 – 5:00 P.M.
Shelby High School Malcolm Brown Auditorium, AV Room
230 East Dixon Boulevard
Shelby, NC 28152

One (1) original and eleven (11) copies of the proposal packet (12 total) must be received at or before 5:00 P.M. on the due date. Proposals should be mailed or delivered to CCS, Attn: Bill McCullough, 315 Patton Drive, Shelby, NC 28150. Proposals received after this date and time will not be considered for this RFP cycle.

CCS will consider the submission of a proposal to constitute agreement by the applicant to all provisions and conditions included in the RFP document and in the attached Memorandum of Understanding.

I. EVALUATION OF APPLICATIONS

A. Evaluation Process

Proposals will be rated through a standardized evaluation process. CCS will establish an evaluation committee, the membership of which shall have no conflict of interest with any respondent to the RFP. The committee may be comprised, among others, of CCS employees, consumers and/or their families or guardians and other community representatives with expertise in the specific needs of the student population. As part of this review process, the review panel may request oral presentations or discussions with any or all interested parties for the purposes of clarification or amplification of all materials presented in any part of the proposal. Site visits to applicant's existing facilities may be conducted as part of the evaluation process.

B. Final Selection/Notification

Upon completion of the response evaluation process a final selection of provider(s) will be made and the selected provider(s) notified. Additionally, those providers not selected will also be notified.

C. Appeals Procedure

Written appeals with respect to this RFP and the final selections must be based upon CCS violation or noncompliance with specific applicable relevant law(s) or regulation(s), which must be cited in writing. Written appeals must be sent to: CCS, Attn: Bill McCullough, 315 Patton Drive, Shelby, N.C. 28150, and must be received no later than 5:00 P.M. upon the fifth (5th) business day following the date the final selection is made public. The determination of the CCS with respect to written appeals shall be final.

II. GUIDELINES FOR SUBMITTING PROPOSALS

All proposals should be submitted in the following format and sequence noted below, including all required attachments. Proposals not following these requirements will not be reviewed.

A. Corporate Qualifications - Place all responses in this section. No attachments

1. Provide your organization's corporate name, corporate headquarter's address, telephone number and number of years established. Also provide the address, telephone number, and years established of your organization's office located in Cleveland County. If your organization

does not have an office in Cleveland County, state that fact. Also list all other locations (by county and state) where your organization is currently providing services.

2. Provide a list of the organization's owners, board members and officers, giving areas of expertise. Provide a copy of your organizations by-laws.
3. In regards to the operation of this program, list the names and qualifications of primary personnel in your organization that would be providing services to these students.
4. Describe in detail your organization's previous experience in providing the services requested under this RFP. Include the number of K-12 consumers served and the length of time served for these consumers as well as level of care. Include the number of K-12 consumers your organization provided CBS services to in the 2004-2005 school year. List the number of consumers by age in a chart form beginning with the youngest age.
5. Provide a copy of current general liability and professional liability insurance, with a minimum coverage of $1,000,000/$3,000,000.
6. Provide a copy of worker's compensation insurance carried by an approved NC carrier, with coverage satisfactory to CCS.

**Maximum Section Score 15 Points

B. Operational Plan - Place all responses in this section. No attachments

1. Attach a copy of your organization's mission, vision and values statement.
2. State your organization's philosophy regarding the provision of services to the students to be served under this proposal.
3. Describe, in detail, all activities that would take place to achieve a transition of a student from a different provider to ensure continuity of care and minimize disruption.
4. Attach a copy of a detailed organizational chart of your agency, including the personnel reflected in this proposal.
5. Include a copy of the organization's current Quality Improvement plan. This must include evidence of Quality Improvement tools and data used to insure positive clinical outcomes for the students served by your organization.
6. Provide information as to how students and families are, or will be, involved in the organizational planning, continuous monitoring and oversight of your organization.
7. Describe, in detail, the clinical best practices adopted and used by your organization in providing the services requested under this proposal.
8. Describe in detail your organization's methods to ensure timely communication and close collaboration with CCS. Specifically what is your organization's policy/protocol:
    - For notifying the school regarding the assignment of a new CBS worker?
    - For responding to requests for information, assistance, and or complaints from CCS?
    - Regarding the attendance of your personnel at school initiated and/or team meetings at school?
    - Regarding accessibility of your management if their involvement is needed to resolve client or service delivery problems with CCS.

9. Describe, in detail, your service capacity for providing the service(s) reflected in this proposal.
10. Describe, in detail, your organization's plan and/or current ability to provide "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis.
11. State the feeder area(s) that you are applying to serve: Burns, Crest, Kings Mountain, and/or Shelby.
12. Describe the composition of your provider team that will serve up to 30 students as detailed in the proposed definition of Community Support. List the number of positions and their roles, e.g. Qualified Professional, Associate Professional, and Paraprofessional.

**Maximum Section Score 60 points

C. Personnel - Place all responses in this section. No attachments

1. List, by position and percentage of time, the staff you would employ to deliver these services in Cleveland County. Clearly indicate for each employee listed, the percentage of time they would be assigned to duties outside of Cleveland County. Also list each staff person's educational degree and any license(s) he/she possesses. Clearly state which employees are licensed to provide substance abuse outpatient therapy. State the percentage of these employees who reside in Cleveland County.
2. Attach a detailed job description for the positions that would provide direct services to these students.
3. Attach staff training curriculum that your organization would provide for the staff of this program. Include special pre-service and in-service training beyond what is required by the state.
4. Provide a detailed listing of all employment benefits offered to employees of your organization. Provide any attachment which offers detailed specific benefit information.
5. Describe your organization's policy/protocol for providing substitute coverage during the school day when a CBS worker is absent. State the date this policy/protocol was initiated and operational.
6. Describe your organization's policy/protocol for responding to personnel issues based on complaints from school personnel. State the date this policy/protocol was initiated and operational.

**Maximum Section Score 15 points

D. Required Attachments

1. Statement of willingness to comply with all requirements of related federal, state or local government legislation or ordinances (for example ADA, EEO, SYNAR, HIPAA).
2. Statement of willingness to comply with attached Memorandum of Understanding between the Provider and CCS. Speak specifically about how your organization will ensure professional attitude, appearance, and behavior among your employees who work in CCS.
3. Letter of interest in responding to the RFP, signed by the organization Board of Director's Chairperson or other official designee.
4. Copies of current Licensure and national local and or state accreditation of all relevant programs operated by this organization.
5. Describe your organization's readiness to apply for and receive endorsement to meet the new Community Support services definition.

**Maximum Section Score 10 points

REQUEST FOR PROPOSAL

School-Sited One-One Community Based Services for Children and Families

School-sited one-on-one community based services for children and families includes screening, assessment, group/family/individual therapies, case management, consultation, education and selective prevention service within the Cleveland County School System.

Cleveland County Schools:
The Cleveland County School system has 28 schools and a student population of approximately 17,000. Services are expected to begin at the start of the 2005-2006 academic year on August 25, 2005. Provider(s) are expected to operate services during the school system schedule and coordinate for the continuing care of consumers during school breaks throughout the year.

Service Descriptions:
Screening is an assessment service which provides for an appraisal of an individual who is not receiving services in order to determine the nature of the individual's problem and his need for services. The service may include an assessment of the nature and extent of an individual's problem(s) through an appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual resources of the individual, for the purposes of diagnosis and determination of the disability, level of eligibility and the most appropriate plan for services.

Evaluation is a continuing assessment service which provides for an appraisal of an enrolled area student receiving services in order to determine the nature of the individual's problem and his need for services. The service may include an assessment of the nature and extent of an individual's problem through an appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual resources of the individual, for the purposes of diagnosis and determination of the disability, level of eligibility and the most appropriate plan for services.

Treatment and Service Provision is a service or services designed to meet the treatment needs of the student. Services may be provided to an individual, families or groups. Counseling, psychotherapy, medication therapy, occupational, physical and other special therapies and collateral work with families or the substitute family members of a client are included.

Case Management is a service that is designed to meet some of the educational, vocational, health, financial, social and other non-treatment needs of the individual. These are activities with and/or on behalf of an enrolled student. Services include the arrangement, linkage or integration of multiple services as they are needed or being received by the individual, advocacy on behalf of the individual, supportive counseling, preparation and revision of service plan, monitoring the provision of services, reviewing documentation of services on behalf of the client, monitoring the provision of the services to the individual, and training or retraining activities required for successful maintenance or re-entry into the client's vocational or community living situation.

MEMORANDUM OF UNDERSTANDING

PROVISION OF CBS SERVICES IN CLEVELAND COUNTY SCHOOLS

Cleveland County Schools and school based principals maintain final authority in determining what services are delivered and by whom to students during the instructional day and/or while on school grounds in all circumstances and reserve the right to deny One-on-One Community Based Services providers access to any student at any time during the instructional day. Cleveland County Schools will permit selected fully accredited Community Based One-on-One Services providers to deliver services to assigned students on school campuses under the following conditions.

1. The agency providing Community Based Services, (THE AGENCY) signs and adheres to all the guidelines set forth in a Memorandum of Understanding with Cleveland County Schools.

2. The Community Based Services (CBS) to be delivered at school have been determined necessary by an interdisciplinary qualified Child and Family Treatment Team via procedures and regulations set forth by Pathways LME.

3. THE AGENCY provides documentation that verifies accreditation, licensure, and inclusion in the Pathways Provider Network to Pathways. THE AGENCY provides, upon request, Cleveland County Schools a copy of its certificate of insurance, employee handbook, policies and procedures outlining guiding principles, mission statement, code of conduct, personnel policies and procedures, basic training, application procedures, clients' rights and confidentiality policies, conflict resolution/grievance/disciplinary action procedures, evaluation procedures, and policy regarding harm, abuse, neglect, and exploitation.

4. THE AGENCY provides evidence prior to delivering services that employees have been trained in and meet the minimum requirements of THE AGENCY's employees, including training in an acceptable curriculum of positive, preventive, and restrictive behavior intervention techniques. Agency employees must have completed criminal background checks, and drug screening prior to reporting to school campuses.

5. THE AGENCY (CBS worker and/or Case Manager) calls the Principal of the school prior to the beginning of services to schedule an introduction of the CBS worker to appropriate school staff. The meeting should include the role of the CBS worker as stated in the Child and Family Plan. The meeting should also include the target goals of the student. A release of information should be signed at the meeting allowing the school to have access to the Child and Family Team plan and the Agency to have access to the IEP if applicable. A student handbook and other pertinent information about the school should be shared with the worker/agency by the school at this time.

6. A letter containing pertinent information should be brought to the introductory meeting:

    - Student's full name and birth date
    - Name of the CBS worker and contact information
    - Name of the provider agency and contact information
    - Name of the case manger/therapist and contact information

- Approved number of hours

7. The CBS worker should sign in and out of the school office each day and wear a visitor's badge. The CBS worker will also need to carry THE AGENCY identification.

8. THE AGENCY notifies Cleveland County Schools of any temporary or permanent change in direct CBS personnel by calling the school principal or designee at least 1 week prior to the change or earlier if possible. THE AGENCY will send a substitute worker for CBS provider who is late or absent unexpectedly, and will notify school staff of the change by calling the school as soon as possible on the day a substitute is assigned. Substitute personnel are subject to all policies and procedures designated in this agreement.

9. Appropriate school based staff and CBS agency staff will participate in unified treatment teams (IEP teams, 504 teams, Child and Family Treatment Teams) prior to CBS services being delivered and as a part of ongoing monitoring of services. Child and Family Treatment Teams meet according to guidelines and IEP/504 teams meet a minimum of once a year. Ongoing communication between the school and THE AGENCY is a must.

10. CBS workers will adhere to THE AGENCY's and Cleveland County Schools policies and procedures (as outlined in each school's handbook) governing confidentiality, food, drinks, gum, sign in and sign out, weapons, dress code, tobacco use,(CCS is a tobacco free school system) NC testing and accountability program, cell phone and pager use, quiet/professional demeanor, and interactions with other students in the classroom. The classroom teacher retains the ultimate responsibility for directing the CBS worker's interactions with student while on a school campus or participating in instructional school functions off campus. The teacher should have full knowledge of the CBS worker's role and the plan provided for the identified student. Behavioral interventions shall be student specific and determined by the unified Treatment Team and IEP/504 Team.

11. THE AGENCY will notify the school of any step down in hours of service or discontinuation of CBS service as soon as this determination has been made by the Treatment Team. THE AGENCY will adjust step down plans according to a student's behavioral response to change in services. If behavior deteriorates, the step down plan will be adjusted accordingly.

12. The worker will remain in close proximity to the assigned student at all times unless the child's plan specifies a modified supervision protocol. Transportation of the student by the CBS worker must be specified in the child's plan and approved in writing by the child's parent.

13. Conflict resolution will be addressed first with the classroom teacher and the CBS worker. If conflict persists, the school principal will become involved and contact THE AGENCY providing the CBS worker. If conflict still remains unresolved, THE AGENCY will be asked to provide a different CBS worker. If THE AGENCY is unable to provide an acceptable and appropriate CBS worker to meet a child's needs within a reasonable time due to conflict or any other cause, another agency with a CCS Memorandum of Understanding will be asked to provide an appropriate CBS worker.

IN WITNESS WHEREOF, Cleveland County Schools Board of Education, and

_____ have executed this agreement on this
(Name of agency)

the _____ day of _____ 2005 for the 2005-2006 school year.

Cleveland County Schools

By _____ _____
Superintendent Date

Cleveland County Schools

By _____ _____
Chairman School Board Date

Cleveland County Schools

By _____ _____
Director of Exceptional Children Programs Date

NAME OF ACCREDITED AGENCY

_____

Address _____

Phone # _____

Email Address_____

Agency Representative_____ _____
Executive Director Signature Date
Please print name _____

Agency Representative _____ _____
Clinical Director Signature Date
Please print Name _____

Memorandum of Understanding between Wake County Human Services and Wake County Public School System

This agreement shall commence on September 1, 2005 and shall remain in effect until terminated by written notification by either party to the other as outlined below.

General Statement of Mission

This Memorandum of Understanding (MOU) is entered into between Wake County Human Services (WCHS) and Wake County Public School System (WCPSS). The MOU outlines the cooperative efforts of both agencies, as well as the expectations, responsibilities, and conditions for the provision of comprehensive health and human services programs. The MOU is intended to facilitate the provision of identified health and human services in accordance with the N.C. General Statutes, and guidelines established both by the N.C. Department of Health & Human Services and the N.C. Department of Public Instruction.

This MOU explicitly establishes the interventions of medical consultations, accurate and timely interpretation of health guidelines, and investigation of reported communicable diseases as identified strategies for promoting student and family success. Both agencies have a vital interest in promoting the physical, psychosocial and behavioral health of children and families to assure that children may function optimally in a learning environment. These cooperative efforts were designed to promote health and school success by providing services for identified children, families, and the community at large. Comprehensive health and human services programs promote individual & public health, life skills, and family support through curricula and designated activities.

Joint Responsibilities of the Parties

WCHS and WCPSS will jointly assure that all staff serving children and families act in accordance with the letter and spirit of this MOU, and are in compliance with the mutually developed comprehensive School Health Program guidelines of the WCPSS *Human Services Handbook*. All staff involved in the delivery of health and human services are considered agents of the WCPSS for the purpose of this agreement and are afforded access to school records and participation in school based team meetings as appropriate. All parties agree to submit appropriate documentation and reports of services rendered, and to develop and update school health services, policies, and procedures in the WCPSS *Human Services Handbook* in a timely and efficient manner. WCPSS and WCHS agree to negotiate both real and in-kind supports to the joint health and human services efforts, and agree explicitly to the responsibilities for coordination of services described for each program and service area listed below. WCPSS and WCHS also agree to execute the attached Business Associate Agreement (BAA), “Attachment A” pursuant to the Health Insurance Portability and Accountability Act (HIPAA). This BAA governs the release of personal health information by staff of WCHS to school personnel for purposes of providing services to children and families, and the obligations of both parties to protect such information.

Responsibilities by Program Area

Student Health
Responsibilities of Wake County Human Services

Wake County Human Services Program Directors will coordinate policies and procedures for school nursing, mental health, and dental outreach with the Wake County Public School System Senior Director for Counseling and Student Services, involving other Wake County Human Services and Wake County Public School System officials as needs indicate:

Provide clinical supervision of school based mental health counselors who will:

Receive and coordinate referrals from School Counselors, Social Workers and other staff for students who need a psychiatric/behavioral assessment
Complete assessments and link students to appropriate services
Provide individual therapy to students at their school sites around mental health issues that are interfering with school performance
Provide Psycho-educational Groups for students with mental health and / or substance abuse issues
Provide crisis counseling as needed to students
Be on call through digital pager for school staff to consult on school based crises
Provide consultations and trainings to school staff around mental health topics
Provide clinical supervision for all school nurses and determine a schedule for periodic visiting of individual school campuses by nurses whose services include:
Consultation to the principal in planning for delivery of first aid and other health services
Nursing assessments of referred students
Vision re-screenings of referred students
Referral and follow-up for identified health needs, including assistance to parents in obtaining health care for students
Consultation and training for school staff in management of chronic illnesses plus specific training for those who perform or assist a student with a medical procedure ordered by a physician

Upon request of parents or school staff, assessment and development of Individual Health Care plans and/or Emergency Medical Plans for students with acute or chronic illness/handicaps who have a potential for medical crisis in the school setting or who may require a special procedure
Training for designated school staff in administering medications and/or other treatments
Training of school staff to review immunization records, and to perform vision and lice screening
Hepatitis B School Site clinics for sixth graders as directed by DHHS.
Individual health counseling
Resource for communicable disease control measures and other health related questions
Limited case management services for pregnant teens and students with chronic health problems
Health promotion activities
Home visiting
Documentation and reports of services rendered
Provide clinical supervision for all school dental hygienists for provision of:
Dental screening and referral for kindergarten, second grade and self-contained special program students and dental education classes for fifth graders at targeted schools.
Screening and referral for students of other grades and schools upon the request of school staff or school health nurse
Assistance to parents and school staff in obtaining dental health care for students with dental needs
Dental health promotion activities at all elementary schools
Provide assistance with curriculum development.

Responsibilities of Wake County Public School System---Student Health

Assure implementation of the policies and procedures of the WCPSS Human Services Handbook by delegation of responsibility to school principals
Assure that each school has designated staff certified in First Aid and CPR
Designate school personnel to be trained in the administration of student medications and to assist students with physician ordered procedures
Allow meeting time at the beginning of the school year for the nurse or other WCHS staff to review significant school health policies and referral procedures with the faculty. To allow time for training by the nurse for staff designated to perform specific medical procedures for individual students.
Assure that WCHS staff assigned to a specific school campus have a designated WCPSS contact person for ongoing communication; a workspace appropriate for services rendered; and an opportunity to participate on school committees or working groups as appropriate
Assign the clinical supervision of all school nurses to WCHS School Health Program
Promote referral of students needing services to appropriate staff and take responsibility for notifying the nurse of students who need Health Care Plans or Emergency Medical Plans
Inform students, parents and staff of the availability of WCHS staff and services.
Provide WCHS staff with a list of “Free and Reduced Lunch” recipients according to state guidelines.
Appoint membership and coordinate meetings for the School Health Advisory Council.

Family Support

Responsibilities of Wake County Human Services

Coordination of WCHS family support services will be assured by periodic meetings of the Director of Youth Services and WCPSS administrative staff as well as by the PES project leaders team.

Collaborate in the implementation of the Partnership for Educational Success (PES) and Ready To Learn Centers (RTLC).
Consult and collaborate between RTLC Coordinators and principals of participating elementary schools for services delivered through the Ready to Learn Centers.
Ensure coordination and delivery of Family Support services through the Partnership for Educational Success (PES) to identified children and families.
Provide on-site Life Skills Groups and Childbirth & Parenting classes by Health Educators and other Maternal and Women's Health staff.
Consult with school staff regarding pregnant and parenting teens with complex issues.
Visit/contact pregnant teens at school if necessary to follow up on continuity of care issues.
Collaborate in the delivery of educational programs during non-school hours and capacity-building efforts to increase the quality and availability of non-school hour youth programs.
Provide facility and preschool educational services to support the functions of Ready To Learn centers.
Provide assistance with curriculum development.
Provide consultation, training and referral information to school staff in support of proper reporting, investigation and follow up of suspected child abuse, neglect and dependency according to N. C. law.

Responsibilities of Wake County Public School System---Family Support

Continue to support the ongoing operation of the Ready to Learn Centers.
Continue to collaborate with WCHS on implementation of the Partnership for Educational Success.

Provide facility and preschool educational services to support the functions of Ready to Learn Centers.

Community Health

Responsibilities of Wake County Human Services

Wake County Human Services Program Managers will coordinate policies and procedures for communicable diseases and health promotion with the appropriate WCPSS staff, involving other WCHS and WCPSS officials as needed:
Communicable Diseases
Provide appropriate follow-up to all communicable diseases.
Provide follow up for WCHS school nurses who have potentially been exposed to blood borne pathogens.
Provide consultation to the Wake County Public School Health Officer regarding students in need of follow up regarding exposure to blood borne pathogens.
Work with school system staff to receive appropriate health-related and attendance data to assist in communicable disease surveillance.
Disaster Preparedness
Provide potassium iodide (KI) to the schools located in the 10.5 EPZ of the Sharon Harris Nuclear Plant, coordinated with the School safety program
Provide adequate supplies for the students, faculty and staff of identified schools
Provide training to teachers, nurses, other staff in KI administration practices
Provide background information and materials to schools for distribution to parents, teachers, and other school staff
Provide consultation to school administration regarding development of KI distribution and administration procedures

Health promotion/diseases prevention
Provide technical assistance with curriculum development in
Provide technical assistance with nutrition education and counseling, food planning and awareness around healthy eating as resources allow
Provide technical assistance in physical activity planning as resources allow
Provide other public health education assistance and materials as requested and as resources allow
Work with schools to promote smoke-free campuses and to provide technical assistance as time will allow developing appropriate smoking cessation programs for students and staff.
Work with school system staff in congregating data necessary to determine Body Mass Indices.
Appoint staff who will attend and participate in School Health Advisory Council Meetings.
Collaboratively engage appropriate school partners in the completion of State and Federal grants.
Keep appropriate school staff informed as to significant public health issues and campaigns.

Responsibilities of WCPSS----Community Health

Communicable Diseases

Provide appropriate follow up for teachers and other school staff who have potentially been exposed to blood borne pathogens, coordinated through the school employee health program and WCHS Communicable Diseases staff.
Report “reportable” communicable diseases as listed in the Handbook.
Provide appropriate health-related and attendance data to assist in communicable disease surveillance.
Disaster Preparedness
Provide potassium iodide (KI) to the schools located in the 10.5 EPZ of the Sharon Harris Nuclear Plant, coordinated with WCHS Community Health staff
Store adequate KI for students, faculty and staff onsite at each school within the 10-mile EPZ
Collaborate with the Community Health to develop School KI protocol
Collaborate with the Community Health to orient teachers, nurses, other staff in protocol for distribution and administration of KI
Communicate KI protocol to parents and monitor declinations from parents for KI administration for their children
Distribute/administer KI following authorization from appropriate state or local officials
Health Promotion/Disease Prevention
Solicit input from WCHS staff on age appropriate comprehensive family life, fitness, nutrition and health promotion curricula for all grades, incorporating principles of health information, health promotion, physical education and fitness, violence and substance abuse prevention
Promote a healthy environment for students, including facilities, food service management, and extracurricular activities.
Enforce smoke free campuses and to develop appropriate smoking cessation programs for students and staff.
Assist WCHS staff in congregating data necessary to determine Body Mass Indices.
Inform the Director of Community Health of the outcomes generated through the School Health Advisory Council.
Collaboratively engage appropriate WCHS staff in the completion of State and Federal grants.
Keep appropriate WCHS staff informed as to significant educational initiatives and campaigns that promote the health, safety, and well-being of children and their families

Funding

Current funding of the activities described above will be provided by each respective agency. Development of budget priorities and grant applications relating to the School Health Program will be a cooperative effort of both agencies. Priority will be given to the other agency when contracting for services that are applicable and available through that agency.

Dispute Settlement

The parties to this Memorandum of Understanding agree that there should be few, if any, disagreements that result in a formal grievance and commit themselves to resolving those disagreements informally though a planning team. In good faith, both parties agree to use all reasonable means to resolve disagreements, but if unresolved, either party may submit a grievance in writing to the appropriate Agency Director. Should the disagreement still not be resolved, each party shall refer the matter to its governing body for further attempts to resolve the disagreement.

Termination

This Memorandum of Understanding may be terminated at any time upon mutual consent of both parties, or upon 30 days written notice of one of the parties. This MOU may also be terminated immediately with cause upon written notice to the other party.

Wake County Human Services	Wake County Public School System
Maria F. Spaulding, Director	Patti Head, Chair, Wake County Public School System, Board of Education
Date:	Date:

ATTACHMENT "A"

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the 1st of September 2003, by and between WCHS, hereinafter referred to as "Covered Entity", and WCPSS, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined in the HIPAA Privacy Rule (the agreement evidencing such arrangement is reflected in a written agreement or purchase order dated December 1, 2002, and is hereby referred to as the "Arrangement Agreement"); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;
THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with the HIPAA Privacy Rule, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Privacy Rule and to protect the interests of both Parties.

1. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in the HIPAA Privacy Rule.
The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is reasonable basis to believe the information can be used to identify the individual.

2. COORDINATION WITH HIPAA PRIVACY RULE

In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Privacy Rule in effect at the time shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Privacy Rule, but are nonetheless permitted by the HIPAA Privacy Rule, the provisions of this Agreement shall control.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information, which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a. Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

b. Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.

c. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement.

d. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

e. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement.

f. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

g. Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Privacy Rule.

h. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Privacy Rule.

i. Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary of Health and Human Services.

j. Business Associate agrees to document any disclosures of and make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Privacy Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

(a) Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Arrangement Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

5. TERM AND TERMINATION

a. Term. The Term of this Agreement shall be effective as of the date first written above, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall have the right to immediately terminate this Agreement and the Arrangement Agreement.

c. Effect of Termination.

(i) Except as provided in paragraph (ii) of this subsection, upon termination of this Agreement, the Arrangement Agreement or upon request of Covered Entity, whichever occurs first, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. MISCELLANEOUS

a. No Rights in Third Parties. Except as expressly stated herein or the HIPAA Privacy Rule, the Parties to this Agreement do not intend to create any rights in any third parties.

b. Survival. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

c. Amendment. This Agreement may be amended or modified only in a writing signed by the Parties. The Parties agree that this Agreement will be automatically amended to conform to any changes in the Privacy Rule as is necessary for a Covered Entity to comply with the current requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

d. Assignment. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party.

e. Independent Contractor. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship.

f. Governing Law. This Agreement will be governed by the laws of the State of North Carolina.

g. No Waiver. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

h. Interpretation. Any ambiguity of this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

i. Severability. In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect.

j. Notice. Any notification required in this Agreement shall be made in writing to the representative of the other Party who signed this Agreement or the person currently serving in that representative's position with the other Party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:	BUSINESS ASSOCIATE:
By:_____	By:_____
Title:_____	Title:_____

Protocol and Criteria for Accessing CBS Services in the School Setting for Children

Purpose of CBS Provision: Situation Specific School Stabilization such as:

- When a child is transitioning to a school situation from a Mental Retardation Center, hospital, PRTF, or other residential placement and the team determines that short-term additional support is needed to ensure success, or
- When a child is waiting for a more restrictive placement, or
- When a child is having extreme difficulty in school (ex: multiple suspensions) which jeopardizes the home/ residential placement.

All of the following criteria must be met:

- ***Consumer must meet medical necessity criteria for CBS-Professional***
- Consumer must be identified within one of the following target populations: CDSN, CMSED, or CMMED.
- Consumer must be insured by Medicaid or Health Choice and be receiving long-term case management. [**Note: If a CMH consumer is not Medicaid or Health Choice insured and will be requesting CMSED or CMMED funding, service approval is dependent upon funding availability.]
- If in CDSN target population, must have a score of 3, 4 or 5 in the Behavior Domain section of the NC SNAP and a formal behavior plan for school based activities in place. The plan includes activities that the CBS worker can implement.
- If in CMSED or CMMED target populations, must have a CAFAS role performance (school) subscale of 30.
- The schools must provide written documentation (such as the current IEP and the most recent IEP conference summary) that they are meeting all the IEP requirements for the child and request short-term CBS support.
- Schools must be in agreement with the phase out plan as indicated by the signature of the Exceptional Children's Director, or their designee, on the consumer's treatment plan.

Protocol

1. The case manager in collaboration with the parent, teacher, Exceptional Children's Director, and other appropriate team members will identify the need for this service.
2. The OPC Case Manager will consult with the Case Management Supervisor regarding the need for this service.
3. The OPC case manager will contact the Exceptional Children's Director of the school system to confirm the time limited request for CBS services in school.
4. EC Director will review request and confirm the need as well as notify the appropriate individuals at the school facility.
5. The case manager will insure the inclusion of appropriate CBS goals on the service plan.
6. Case manager will follow previously established procedures for authorizing CBS services.

7. This service can be provided for a maximum of 8 weeks and for no more than 240 hours total.
   The 240-hour maximum applies only to CBS services provided at the school.

Utilization Review requirements: The case manger will remain in close contact with the child's teacher and parent to help ascertain the effectiveness and need for CBS in school. The IEP will be revisited and/or revised during this period as needed.

Memorandum of Agreement Between Agencies in Person County to Develop a Coordinated System of Care

For Children with Serious Emotional Disturbance and Their Families

Orange-Person-Chatham Mental Health Center, Person Department of Social Services, Person Juvenile Court, Person County Schools, Person Guardian ad Litem Program, and Person County Health Department, agree to develop a Community Collaborative in conjunction with parents, non-profits and community members to order to have a system of care that increases collaboration for the benefit of children with complex and multiple emotional needs and their families and demonstrates improved outcomes for these children. The Community Collaborative will develop a framework for agencies, families, and the natural resources of the community to work together to meet the needs of children with serious emotional disturbance and their families.

The Community Collaborative will work from the following values and principles to develop this system of care:

Values:
1) focus on families' needs and priorities
2) base services in the community to reduce need for out-of –home placements
3) promote cultural competence

Principles:
Children with complex and multiple emotional needs should
1) have access to a comprehensive menu of services to meet their educational, social, emotional , and physical needs
2) receive services in the least restrictive environment that is appropriate
3) receive services that are individual, strength-based, and specific to them and their families' needs and potentials
4) have their families fully involved in developing and carrying out of plans
5) receive services that are coordinated between agencies
6) have case management services that can change as the child and families needs change
7) be identified early and have access to early intervention
8) have a smooth transition to adult services
9) receive services that are sensitive to the culture and special needs of each child and their family and strengthens their connection to natural community supports(extended family, neighbors, faith communities)
10) be part of a system that protects their rights and promotes advocacy

In order to develop a coordinated Person System of Care for children with serious emotional needs and their families we the undersigned agree to the following:

To Provide Appropriate Staff to Participate on Community Collaborative and Subcommittees

The core functions of the Collaborative include:

a) Establishing the collaborative relationships and procedures necessary for carrying out its functions.
b) Identifying and coordinating existing resources across child-serving agencies and within the community to increase service/support access, divert children from unnecessary out of home placements, including foster care, and return children placed out of the community;
c) Working as the planning and advisory body for the use of Comprehensive Treatment Services Program funds. In this capacity, the Collaborative will have joint accountability and responsibility with OPC-LME to ensure the effectiveness of the Comprehensive Treatment Services Program;
d) Assuring that At Risk (CTSP: Comprehensive Treatment Services Program) funds are utilized in a manner that promotes services that are outcome-based, clinically appropriate and medically necessary to achieve the goals of preventing unnecessary use of foster care, youth academies and state hospitals;
e) Identifying needs and implementing training and technical assistance related to ensuring that a coordinated countywide system free of barriers for care is established across agencies.
f) Drawing from the experience of Child and Family Teams and other available resources to continuously assess the need for additional resources and provide effective, collaborative leadership toward that goal.
g) Determining operational logistics of the Collaborative (i.e. who will serve as Chair, meeting procedures, conflict resolution, sub-committee development, etc.);
h) Assuring the accurate and timely reporting of information to the State Collaborative.
i) Ensuring that Child and Family Teams operate and make decisions within the parameters of policies and procedures for the target population in accordance with the Comprehensive Treatment Program Special Provision, Olmstead requirements, and related State policy.
j) Advising local and state officials about the needs (e.g. services, support, policy, etc.) of children at risk of not succeeding and their families.
k) Identifying service gaps and developing plans to fill priority service gaps

To Support and Facilitate Participation of Direct Care Staff on Child and Family Teams

Child and Family Teams will be developed around children with complex and multiple emotional needs who are at-risk for placement outside the home. The teams will consist of agency staff, parents or caregiver, caregiver's natural supports (extended family, neighbors, ministers) and the child if appropriate. The strength based plan that the family and Team develop will be the basis of all agency plans involving the family and child. The development of one coordinated plan increases likelihood of better outcomes.

To Support Training

Trainings within and across agencies are needed to implement a System of Care including trainings on partnering with parents, use of strength based assessments, and participation on Child and Family Teams.

To Development of Common Language

The decrease in use of jargon and acronyms will increase understanding and cooperation between agencies and parents.

To Support the Promotion of System of Care Values Within Each Agency

Better outcomes for children with serious emotional disturbance and improved agency coordination can be accomplished if agencies promote System of Care values within each of their agencies. Agencies are asked to particularly focus on partnering with families (especially no development of plans without parents except in extreme circumstances), cultural competence, increasing coordination, and focusing on family, child, and community strengths.
In order to promote cultural competence in my agency and to develop a system wide cultural competence plan that includes training, my agency agrees to share information about any cultural competence self assessment already completed, training and other resources and to use those results/resources to aid in the development of a comprehensive cultural competence plan.

To Support Education
My agency agrees to assist in educating the general public about risk factors and emotional, social, physical, and educational needs of children in our community. This education can reduce stigma for children who are struggling and provide encouragement for creating supportive environments for a wide range of children and their families. Agencies are also asked to educate the Community Collaborative on their services, mandates/missions, and funding sources to enhance greater understanding between agencies. Agencies are also asked to educate their staff re: System of Care efforts.

This Memorandum of Agreement is executed by the individuals listed below who are acting in their official capacities.

Appendix I. Resources to Assist Parents and Family Members

North Carolina Public Schools

NC Department of Public Instruction

www.ncpublicschools.org/organization/

The North Carolina Department of Public Instruction is the agency charged with implementing the State's public school laws and the State Board of Education's policies and procedures governing pre-kindergarten through 12th grade public education. The elected State Superintendent of Public Instruction heads the Department and functions under the policy direction of the State Board of Education. See also:
http://www.ncpublicschools.org/ec/
http://www.ncpublicschools.org/ec/policy/policies/spp/
http://www.ncpublicschools.org/ec/behavioral/initiatives/positivebehavior/

No Child Left Behind – in North Carolina

www.ncpublicschools.org/nclb

The No Child Left Behind Act, signed into law in 2002, has expanded the federal role in education and set requirements in place that affect every public school in America, including those in North Carolina. At the core of No Child Left Behind are measures designed to close achievement gaps between different groups of students. This Web site addresses key NCLB elements as they are implemented in North Carolina including methods of measuring progress in students' academic achievement, standards for teachers, and ramifications for Title I schools.

Americans with Disabilities Act (ADA)

www.ada.gov

Information and technical assistance on the Americans with Disabilities Act.

Exceptional Children's Assistance Center (ECAC)

www.ecac-parentcenter.org

Since 1980, The Exceptional Children's Assistance Center (ECAC) has grown from an all volunteer parent organization to a full service Parent Training & Information Center serving families in North Carolina with more than 25 full and part-time staff and offices throughout NC. All services are provided at no charge to parents and families.

NC Families United

www.ncfamiliesunited.org

North Carolina Families United's mission is to "link families of children with serious emotional, behavioral or mental health challenges to state and community partners for the purpose of improving the lives of these children and their families." NC Families United believes that the

best way to help families and their children improve their lives is through support, information, and advocacy. Parents/caregivers should be full partners in the treatment of their children.

U.S. Department of Education www.ed.gov

US Special Education Programs - Positive Behavioral Interventions and Supports

www.pbis.org/main.htm

The Center has been established by the Office of Special Education Programs, US Department of Education to give schools capacity-building information and technical assistance for identifying, adapting, and sustaining effective school-wide disciplinary practices.
Technical Assistance Web Site

No Child Left Behind – at the Federal Level

www.ed.gov/nclb/landing.jhtml

No Child Left Behind is the historic, bipartisan education reform effort that President Bush proposed his first week in office and that Congress passed into law on January 8, 2002. The No Child Left Behind Act of 2001 (NCLB) reauthorized the Elementary and Secondary Education Act (ESEA) -- the main federal law affecting education from kindergarten through high school. NCLB is built on four principles: accountability for results, more choices for parents, greater local control and flexibility, and an emphasis on doing what works based on scientific research.

Individuals with Disabilities Education Act (IDEA)

www.ed.gov/about/offices/list/osers/osep

The Individuals with Disabilities Education Act (IDEA) (formerly called P.L. 94-142 or the Education for all Handicapped Children Act of 1975) requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment appropriate to their individual needs. IDEA requires public school systems to develop appropriate Individualized Education Programs (IEP's) for each child. The specific special education and related services outlined in each IEP reflect the individualized needs of each student. State agency's decisions can be appealed to State or Federal court. For more information, contact: Office of Special Education Programs (202) 205-5507 (voice/TTY)
Office of Special Education and Rehabilitative Services
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, D.C. 20202-7100

Rehabilitation Act

www.ada.gov

The Rehabilitation Act prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in programs receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in title I of the Americans with Disabilities Act.

Other Resources include:

http://www.ncei.org/ei/index.html and http://www.nchealthyschools.org/

Appendix J. Acronyms

The following is a limited list of the most commonly used acronyms by educators or by MH/DD/SA professionals in reference to services for children. More expansive lists can be found on the web sites of DPI or DMH/DD/SAS. See: http://www.ncpublicschools.org/acronyms/

CAP	Community Alternatives Program
CAP–MR/DD	Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities
CDSA	Children's Developmental Services Agency
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare/Medicaid Services
DD	Developmental Disability
DHHS	Department of Health and Human Services
DJJDP	Department of Juvenile Justice and Delinquency Prevention
DMA	Division of Medical Assistance
DMH/DD/SA	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DPH	Division of Public Health
DPI	Department of Public Instruction
DSS	Division of Social Services
ECAC	Exceptional Children's Assistance Center
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESEA	Elementary and Secondary Education Act.
HIPAA	Health Insurance Portability and Accountability Act of 1996
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
LEA	Local Education Agency (Local Public School System)
LME	Local Managing Entities
MAJORS	Managing Access for Juvenile Offender Resources and Services
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mentally Retarded
NAMI	National Alliance for the Mentally Ill
N.C.	North Carolina
NC TOPPS	North Carolina Treatment Outcomes and Program Performance System
PATH	Homeless (PATH) - Child or Adult Mental Health Population

RFA	Request for application
RFI	Request for information
RFP	A Request for Proposal
SAD	Substance Abuse Disorder - Child
SED	Seriously Emotionally Disturbed
SOC	System of Care
SPM	Severe and Persistent Mental Illness
TEACCH	Treatment & Education of Autistic and Related Communication Handicapped Children
TITLE I	Federal funding program
TITLE III	A section of No Child Left Behind funding
TITLE IX	A section of the Educational Amendments of 1972

Appendix K. Glossary[30]

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.
ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes. On example of advocacy and consumer empowerment is participation in state or local CFACs.
AREA/COUNTY PROGRAM – A program that is certified by the DHHS Secretary to manage, oversee and sometimes directly provide mental health, developmental disabilities and substance abuse services in a specified geographic area. Most area programs have already changed or will soon be changing to Local Management Entities.
BASIC BENEFITS – Individual or group outpatient therapy for people with less severe needs who are Medicaid eligible. For children 26 units of service are pre-authorized.
BEST PRACTICE (S) – Interventions, treatments, services or actions that have been shown to generate the best outcomes or results. The terms, evidence-based, or research-based may also be used.
CAP/MR-DD WAIVER – A Medicaid community care funding source for persons with MR/DD who require an ICF/MR level of care that offers specific services in the community.
CATCHMENT AREA - The geographic part of the state served by a specific local management entity as an area or county program.
CATEGORICAL FUNDING – Funds provided for specific purposes or for services to specific people.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - The federal agency responsible for overseeing the Medicare and Medicaid programs.
CHILD AND FAMILY TEAM – A team of people chosen by the family and Community Support provider to develop and monitor a child's person-centered plan including both family and friends and professionals.
CLAIM – An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.
CLIENT - An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee. See also **CONSUMER.**
CLINICAL SERVICES - In mh/dd/sa services, this usually means activities of medical and related professionals. These professionals generally include psychiatrists, social workers, psychologists, nurses and counselors.
COMMUNITY SUPPORT – In this document refers to a Medicaid approved service for children with mental health or substance abuse disorders that provides interventions focused on skill building and including responsibility for the development of person-centered plans with a child and family team, case management functions, and for providing most of the services in the home or other community locations rather than being office based.
CONSUMER – An individual who has been or is receiving publicly funded mental health, developmental disability or substance abuse services or supports. See also **CLIENT.**
CONSUMER OUTCOMES - The extent to which individuals receiving services and supports designed to assist in this process reach their life goals. For example, an adult consumer is competitively employed or a child with severe emotional disturbance who attends school regularly.

[30] See the DPI Exceptional Children Division web site for an additional glossary and list of acronyms. http://www.dpi.state.nc.us/ec/

CO-OCCURRING DISORDERS – The presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions). See also, **DUAL DIAGNOSIS**.
CORE SERVICES – Services such as screening, assessment, crisis or emergency services available to any person who needs them. Also, universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.
CRISIS – Response to stressful life events that may seriously interfere with a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself.
CRISIS INTERVENTION - Services and supports aimed at helping a person manage a crisis safely and return to his or her regular life.
CRISIS SERVICES – Immediate response to assess for acute mh/dd/sa service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate crisis stabilization services. These services are available 24 hours per day, 365 days per year.
CRISIS STABILIZATION – Services and supports following crisis response that are intended to assist the person in crisis to return to his/her regular life.
CULTURAL COMPETENCE –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing acceptance and understanding of others.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees state government human services programs and activities.
DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:
a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay. GS131D-2
DIAGNOSTIC ASSESSMENT - An intensive clinical and functional face to face evaluation of a recipient's mental health or substance abuse condition that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes an order for enhanced benefit services that provides the basis for the development of an initial person-centered plan.
DIRECTLY ENROLLED PROVIDER - Provider organizations that provide services and seek reimbursement from Medicaid. Such providers are subject to the LME endorsement process.
DIVERSION PROGRAMS - Programs designed to screen people out of the criminal justice system and into appropriate treatment services before they are imprisoned. In North Carolina diversion programs are in place in response to SB859 which prohibits admission of persons with mental retardation to public psychiatric hospitals.
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DUAL DIAGNOSIS – Having more than one disorder or condition such as physical illness and mental illness, mental illness or developmental disability and substance abuse. Since the word dual implies two and it is possible for an individual to have many conditions or disorders, CO-OCCURRING DISORDERS is the more accurate term.
EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) – Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.
EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. See also, **PREVENTION**. Also, activities or programs designed to ensure that service providers are competent to provide services; identified as best practices.
EMERGING PRACTICES - Treatments and services that are promising but less thoroughly documented as defined by the President's New Freedom Commission on Mental Health
ENHANCED BENEFITS – Refers to the enhanced benefit service definition package for persons with complicated service needs. The service philosophy includes expectations of "no wrong door," access to service 24/7/365, and service that begins with the first contact with a provider. For persons receiving enhanced benefits, initial treatment or service occurs at the same time that a Diagnostic Assessment is ordered and person-centered planning begins.
EVIDENCE BASED PRACTICES - as defined by the Institute of Medicine (IOM), is the integration of best research evidence with clinical expertise and patient values.
FAMILY SUPPORT – Persons identified by the consumer as either family members or significant others who provide the necessary support for furthering quality of life, attainment of personal life goals or recovery.
HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other non-appropriated funds.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current service consumers are not discriminated against based on health status.
INTERVENTION - Activities aimed at interrupting an action or a behavior that is harmful to progress and recovery.
LOCAL MANAGEMENT ENTITY (LME) - The local agency that plans, develops, implements and monitors services within a specified geographic area according to requirements of the DMH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services and/or supports for both insured and uninsured individuals. See also area/county program.
MEDICAID – A jointly funded federal and state program that provides hospital and medical expense coverage to low-income individuals and certain elderly people and people with disabilities.
MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided. Review methods include retrospective, concurrent and pre-treatment reviews. See **UTILIZATION REVIEW**.
MEMORANDUM OF AGREEMENT (MOA) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.
MEMORANDUM OF UNDERSTANDING (MOU) – Same as MOA
MENTAL ILLNESS – Collective term for all mental disorders. See also, **MENTAL HEALTH, SERIOUS MENTAL ILLNESS,** and **SERIOUS AND PERSISTENT MENTAL ILLNESS**.

MODEL FIDELITY – Adherence to evidence based practice (EBP) and fidelity to those specific program models that are shown to product consistently effective results.
NATURAL SUPPORTS - Places, things and, particularly, people who are part of our interdependent lives and whose relationships are reciprocal in nature and often vital to consumers' welfare.
OUTCOMES MEASURES – At the individual level, events used to determine the extent to which service consumers improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, these are events used to determine if the system is functioning properly.
OUTPATIENT SERVICES – A collection of services for persons with mental illness or addiction disorders. They may include any of the following but are not limited to assessment, medication management, psychotherapies, family therapy, care coordination or case management, supportive employment programs, housing assistance, rehabilitation programs and activities, Assertive Community Treatment (ACT), Homeless Outreach, prevention programs, and others. Outpatient services can be provided in a variety of settings, including the person's home, and contain a few or any number of service elements.
PERSON-CENTERED PLANNING - A process concerned with learning about the individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. The planning process is interested in learning who the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community mh/dd/sa system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.
PROVIDER – A person or an agency that provides mh/dd/sa services, treatment, supports.
PSYCHOSOCIAL REHABILITATION – A variety of social, learning, vocational and community living skill-building programs. Programs that focus on principles of recovery often achieve very successful outcomes.
PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly funded services to consumers.
SCREENING – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.
SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people under 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services.
SEVERELY MENTALLY ILL (SMI) – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.
SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people whose mental disorder is so severe and chronic that it prevents or erodes development of their functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-

making, interpersonal relationships, social transactions, learning and recreational activities. Same as **SERIOUS, DISABLING MENTAL ILLNESS AND CHRONIC MENTAL ILLNESS.**

SERVICE – A fixed and defined arrangement, such as social work services or nursing services, which are delivered within a scope of professional practice.

SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

SUPPORTS – Any of a large number of flexible activities or material resources intended to assist people to gain and maintain meaningful lives as citizens of their communities. See **NATURAL SUPPORTS, PAID SUPPORTS**

SYSTEM OF CARE (SOC) – A framework and structural approach to arranging the delivery and coordination of services for children and adolescents that employs evidence based thinking and arranges a comprehensive array of mental health and other services into a collaborative network to meet their multiple needs. The key principles of SOC are: the child and family are involved in the planning and delivery of treatment and services, services are coordinated and integrated, services are community-based in order to maintain the child in the family and in the community, and the system must be culturally competent in order to be most responsive to the child's and family's needs.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available considering resources within the public system. See also, **PRIORITY POPULATIONS**.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

TREATMENT - The planned provision of services that are sensitive and responsive to a patient's age, disability, if any, gender and culture, and that are conducted under clinical supervision to assist the patient through the process of recovery.

TRIAGE - One name for a process by which people are assessed to determine the type of services and level of care they will require.

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM) - a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. UM is typically an externally imposed process based on clinically defined criteria.

UTILIZATION REVIEW (UR) - an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally imposed process that employs clinically established criteria.

Text from DVD Presentation

by Dr. Mike Lancaster, Chief of Clinical Policy, DMH/DD/SAS, DHHS
and
Diann Irwin, Section Chief, Exceptional Children Division, Department of Public Instruction

Why the change from CBS to Community Support Services?

Mike Lancaster:

Hello I'm Mike Lancaster, Chief of Clinical Policy.

As you are all aware, the NC system is going through reform and community-based services are changing to community support services in the context of the school system. You've gotten together today to discuss these changes and the options that are available for these students.

Joining me today will be Diann Irwin of the Exceptional Children Division from the Department of Public Instruction.

1. Mental Health Reform legislation

a. The reform of the mental health system began in 2001 with a legislative mandate to transform the way services for mental health, substance abuse, and developmental disabilities were provided in North Carolina.

b. The goal of this transformation is to move to evidenced based and best practice models of care provided in a family based community setting.

2. Best practices for children--

a. The effort is to provide a stable community setting with necessary supports to maintain children in their families or family-type settings.

b. This also suggests that the child should be maintained in a consistent school setting as much as possible.

3. Higher quality more focused with better supervision--

a. A component of the reform is to move away from the CBS service that has been provided to children to support them in the school, to a new service definition called Community Support. Children currently receiving CBS will receive Community Support.

b. We hope to develop a more focused intervention in the school setting.

4. Movement towards more skill building for student and family with support and consultation available with school personnel who work with the child--

a. The CS will be focused on skill building with specific goals and focused interventions to support the child in developing his or her own skills to monitor and control their behaviors in a school setting.

b. The goal of this intervention is to support autonomy and independence for the child as they learn to control their own behaviors in a school setting.

c. This intervention will also work in collaborative fashion with the school personnel to develop specific interventions that will be effective in supporting the child in remaining safely and appropriately in the classroom setting.

What is the vision for the local partnership?

Mike Lancaster:

1. The goal of reform is to be family and child focused and community based.

a. Ultimately the goal is to bring services for a child and family together to assist the student through a collaborative effort to keep the child in school and in the community.

b. This is about enhancing the lives of children and families in the community.

2. The active involvement of the schools in this reform effort is imperative.

a. If we can succeed in keeping students in class and ultimately graduating, we will have addressed collaboratively many of the problems causing our drop out rate to be unacceptably high.

3. a. Many of the children using these services are often involved in each of the child serving agencies including the school, DSS, DMH, and at times Juvenile Justice.

b. We need to coordinate our efforts through child and family teams, the IEP process, and the development of person centered plans.

c. This will encourage not only professional interventions, but bring together the supports for family and children in their communities and among their families.

4. Child and family teams collaborate with all at the table and community based meetings (good location might be the school setting) in the community.

5. Person-centered planning including natural and community supports, school services, mental health services, crisis planning.

Diann Irwin:

a. It is very important that school personnel participate in Person Centered Planning of the Child and Family Team for the individual students served by LMEs and LEAs.

b. In addition, school personnel should invite the providers of Community Support services to be members of the student's Individual Education Program team.

c. All parts of the student's plan and services, school and community, should work together to support the student in all activities and environments.
d. The school system should also be sure to actively participate in the local community collaborative which has been developed to find better ways to serve the needs of all students in the community and schools.

e. Participation will enhance local partnership between the agencies that work with all students in the school.

How will the transition work?

Mike Lancaster:

1. Who is affected by this change in services?

a. Children who currently receive CBS services in school will have access to receiving Community Support services as medically necessary.

a. The only exception to this is children with Developmental Disabilities will not be able to access Community Support services. Efforts to secure a separate definition to apply to this group were not accepted at the federal level.

b. Schools and the Division are in active discussions to address the specific needs of these children on a case by case basis.

b. Community Support provides elements of case management and CBS services, but is a more focused, higher level intervention geared to developing individual skills, and autonomy in the children it will support.

c. Over time the service will mature, and become more intense with higher expectations, more supervision, and quality oversight provided by the LMEs to assure the outcomes and goals described are being achieved.

d. This will be an active service, moving toward specific goals for each child using this service.

2. When does this transition occur?

a. This new service will begin on March 20th, and will initially be similar to the service of March 19th.

b. On Monday, March 20, 2006 Community Support services can be billed and CBS will be eliminated.

3. How are Community Support services being implemented?

a. Each LME will assess the medical necessity for Community Support and determine the duration and frequency provided in the school.

b. This decision will include the school, providers, family, and child in determining the amount of the service to be provided as medically necessary to meet the identified goals.

c. In the initial transition phase, the frequency and duration of Community Support may be very similar to the CBS service provided today, with reviews of additional requests conducted at points the IEP is reviewed, or re-authorization through the LME will occur, or a new PCP is developed.

d. These reviews will be conducted in the context of and with recommendations from the child and family teams.

4. The process of transition will be one of gradually maturing of providers delivering the full definition of Community Support.

a. On March 20 the services received by many children will not appear that different, but over time the type of service and the number of hours of service in the school environment will change.

b. In order to provide community support the provider of this service must be endorsed by the LME. This endorsement will assure the providers have met qualifications for this definition to provide community support in the school setting.

5. a. The crosswalk for community support services will in most instances be identical to the authorization of CBS and case management.

b. For those with the most critical needs, attention is needed by the child and family team to plan services immediately.

c. For the majority of children served by community support on March 20th, the authorization of services will be automatic. Changes in the frequency and duration of community support can be reviewed at their annual IEP or at the anniversary or development of the PCP.

6. There are a limited number of children with developmental disabilities who will lose CBS services and will not be eligible for Community Support. This is a small group in the state but it is critical to meet their needs. These will be addressed on a case-by-case basis.

Diann Irwin:

1. The role of the school is to facilitate this transition.

2. School personnel should be proactive in identifying the children in their schools who currently receive CBS and their current providers and contact the LME to ask if Community Support services will be authorized for each child.

a. The school system should identify which students have CBS workers in the school right now.

b. They should also identify the private provider delivering those services.

c. This information will likely be available at the local schools.

3. In the best effort to help students the process must be collaborative (LEAs and LMEs working together to identify and plan for these students.)

a. Someone from the school system should then contact the LME to find out if these students will be authorized for Community Support Services beginning March 20.

b. The LME may not immediately have an answer as it may be necessary to have a meeting about the services for these students.

c. A school system representative should attend the Person Centered Planning meetings to provide information about the student's needs at school.

5. Each LEA must examine existing school programs and staffing to determine if changes in programming needs to occur to meet the needs of those students who may not be covered by the new service definitions. Each student's IEP team must meet to determine what the student needs to receive in the current education program. Some children may be eligible for additional funding through Special State Reserve fund. Information can be found on the Exceptional Children Division web site.

a. If the amount of services is reduced or the service will no longer be available, as in the case of students with developmental disability diagnosis and no mental health diagnosis, the Individual
Education Program team for the student should meet as soon as possible.

b. The current provider of CBS should be included at that meeting.

c. During the IEP meeting, the IEP team needs to consider what services and supports the student will need in order to continue to benefit from education at school.

d. This does not mean automatically providing a one-on-one assistant to these students.

e. In many cases the existing program and staff may be able to provide the supports needed for the student.

What tasks are to be accomplished at the local level?

Mike Lancaster:

1. We are requesting that each LME and each LEA work collaboratively to plan for this transition locally and provide consultation to each other as needed. This is an opportunity to build a strong relationship between the LME and the LEA in order to effectively communicate these changes to the families and children we serve. These changes will in most instances be difficult and anxiety-provoking for the families involved. It is critical that we communicate frequently and effectively.

2. The issues addressed today can be found in a workbook that describes many of these transition issues as points for discussion and decision for each LME and LEA.

3. The workbook was developed by a taskforce of DPI, LEA, LME, providers and Division representatives and reflects some examples of successful collaborations between LME/LEA, other agencies and families and children.

Diann Irwin:

4. The workbook has been developed with the participation of staff from several school systems. It includes information and examples that may be very helpful during this transition. Some of the documents have been developed by other LEAs as they have struggled with how to most effectively work with private providers in their school system.

5. The workbook contains description of the issues, information to assist in making decisions about how to operate, and examples of practices that have been successful in various NC counties

6. The workbook and DVDs have been distributed through the LMEs for single point of distribution but are designed for use by LEAs, individual schools, providers, families and advocates as well as
LMEs.

Diann Irwin:

7. Recognizing that each LEA is autonomous, we realize that the agreements may differ from county to county.

8. This workbook can be found at the following website.

Conclusion

Mike Lancaster:

We hope that presenting these issues today will more quickly begin the discussion to help this transition to embrace community support as a best practice model for care in all of our schools in NC.